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CHILD
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Editorial

THE EARLY DEVELOPMENT OF CHILD PSYCHIATRY IN CANADA

Organized effort in the field of child psychiatry began with the establishment of a child guidance clinic in Montreal in March 1923, when the first attempts were made to combine the skills of psychiatry, psychology and psychiatric social work in a team approach to dealing with behavior disturbances in children. For some years prior to this there had been considerable psychiatric interest in juvenile delinquency, mental deficiency and school failures in children but this was manifested primarily as part of general psychiatric clinic activity in out-patient psychiatric clinics which had been established in the Toronto General Hospital and the Royal Victoria Hospital in Montreal.

The impetus for this whole development was given by the formation, in April 1918, of the Canadian National Committee for Mental Hygiene, now known as the Canadian Mental Health Association, with headquarters in Toronto and a branch activity in the Montreal area. The dynamic leadership of Dr. C. K. Clarke and Dr. C. M. Hincks helped to lay the foundation for the development of psychiatry in Canada as we know it to-day. It is noteworthy that these men founded the Canadian Journal of Mental Hygiene in April 1919, which for a period of several years served the same purpose as does our present Canadian Psychiatric Association Journal.

It was my privilege to work with the Editor of this Journal, Dr. Gordon S. Mundie, and to be associated with him in the development of the Montreal Child Guidance Clinic. The pattern of this clinical work was essentially that of the Demonstration Child Guidance clinics, which the National Committee for Mental Hygiene in the United States had begun to operate in order to focus attention on the importance of treating behavior disturbances in children as part of an over-all community mental health program. The Child Guidance Clinic in Montreal rapidly became a centre to which social agencies, the juvenile court and the schools brought their child psychiatric problems and the community recognized this important contribution by assuming financial support for this work through the organization, which is now known as Welfare Federation, Red Feather Services. The large numbers of children referred to this clinic for diagnosis and treatment so taxed the facilities of the clinic quarters, which had been established in an office building in the business district, that the clinic premises were moved in 1929 into a building owned by McGill University when the clinic obtained a Charter from the Province of Quebec and began to operate as the Montreal Mental Hygiene Institute.

It is noteworthy that this whole development, which has culminated in the organization of child psychiatric facilities in hospital centres and in the numerous mental health clinics throughout the country, is in considerable measure due to the public interest which was created by numerous surveys of the child population, particularly in public schools. Immediately following the First World War and for a period of several years thereafter, the Canadian Mental

Health Association made extensive mental health surveys of various population groups and the findings of these surveys indicated clearly the great need for the early detection of mental retardation, abnormal behavior and anti-social conduct in children and young people.

The Canadian Journal of Mental Hygiene in its first issue in April 1919, states in its leading editorial that teachers and parents are becoming greatly concerned about the fact that the problem of the abnormal child in the school has not been properly solved in this country and that special facilities are needed in the school system to cope with these difficulties. In subsequent issues this Journal has numerous articles on what was then called feeblemindedness in children, the importance of psychological testing of children in order to estimate their learning capacities, the general problem of juvenile delinquency and the importance of developing in teachers and parents a special awareness of the need to cope satisfactorily with various types of behavior disturbances in children.

It is interesting to note that in the first issue of this Journal, repeated references are made to the difficulties under which the pioneers in this field worked and the obstacles they had to surmount because considerable time had to elapse before the general medical profession and the public at large developed an appreciation of the need for adequate facilities and trained personnel for this work. An article written in April 1919, by Dr. C. K. Clarke, on the Story of the Toronto General Hospital Psychiatric Clinic, outlines in considerable detail the problems which they encountered in attempting to establish in Canada the first psychiatric clinic in a general hospital. It is of special interest to note that while this clinic concerned itself primarily with adult psychiatric problems, reference is made to the fact that a goodly proportion of the children sent to this clinic proved to be suffering from mental diseases in the early stages and that a considerable proportion of the children referred to them came from the Toronto Juvenile Court.

In the mid twenties, the Canadian Mental Health Association succeeded in obtaining substantial financial assistance from the Laura Spellman Rockefeller Foundation and initiated a research program in child development which resulted in the establishment of St. George's School for Child Study in Toronto and a McGill University Nursery School Study Centre in Montreal. Over a period of several years these projects created widespread interest in the whole field of child behavior and laid the foundations for the development of the numerous present day child psychiatric centres in Canada.

Résumé

L'auteur rappelle les origines de la psychiatrie infantile dans notre pays, au moment de la fondation d'une clinique de santé mentale pour les enfants, à Montréal, en 1923. Jusqu'à ce jour les problèmes psychiatriques des enfants étaient dirigés vers les centres hospitaliers pour adultes.

L'organisme responsable de cette initiative était l'ancêtre de notre Association Canadienne pour la Santé Mentale.

La clinique était financée par les sociétés de services sociaux qui se groupèrent plus tard pour former le Conseil des Oeuvres (Red Feather). Les besoins se firent sentir de plus en plus nombreux, jusqu'à nécessiter des locaux plus spacieux et la fondation de l'Institut d'Hygiène Mentale affilié à l'Université McGill (1929).

A partir de ce moment, le mouvement de croissance de la psychiatrie infantile s'est déplacé vers des centres hospitaliers spécialisés, et s'est intéressé de plus en plus au dépistage des enfants exceptionnels dans les écoles.

B. SILVERMAN

CHILD PSYCHIATRY ACROSS CANADA: AN OUTLINE OF CURRENT FACILITIES AND RESOURCES

JEAN L. LAPOINTE, M.D.[1]

Since the C.P.A. Annual Meeting in 1958 a group of psychiatrists more particularly interested in problems of children have been patiently working at exchanging ideas, comparing resources and discussing standards, slowly shaping the future of child psychiatry in Canada. Out of pre-convention meetings and through difficult channels of communication across our vast country, networks have been established and committees have set forth to work on various objectives.

A Nucleus Committee was formed which was designed to gather information from provincial representatives and redistribute it to the membership at large.

The present special issue of the C.P.A. Journal, and more specifically the present paper, stem from such a joint effort and innumerable credits should go to all those who helped the Committee assemble and prepare the following material.

In order to keep within the allotted space, some of the detailed information obtained from certain areas will unavoidably be condensed. Our aim is to give a rapid description of the present state of Child Psychiatry as it is practised and taught across the country, for the benefit of our (less specialized) psychiatric and non-psychiatric colleagues.

Newfoundland:

There are no specific child psychiatric facilities available in this province. Children are screened and assessed through the out-patient department of the Hospital for Mental and Nervous diseases. Planned additions to the St. Johns General Hospital should include a larger pediatric division with some facilities for the treatment of emotionally disturbed children. Two psychiatrists in private practice see children on a consultative basis but cannot undertake treatment.

Training opportunities for post-graduate students in child-psychiatry are non-existent. A two year post-graduate course for residents in the above hospitals is limited to adult psychiatry in affiliation with Dalhousie University (N.S.).

New Brunswick:

Lack of staff at the professional as well as at the auxiliary level is the main problem in this province. Mental Health Clinics are set up for screening and treatment of psychiatric problems in the heavily populated areas, and 30% of their case-load is made-up of children. In Moncton special facilities for mentally retarded children and special classes for emotionally disturbed children in schools are available.

There are no training facilities in this province.

Nova Scotia:

Child psychiatry is practised in the six mental health clinics established throughout the province. Most of the psychiatrists in the region have not had special training in child psychiatry. Thirty percent of the referrals are children and a fair proportion of these are carried in treatment. The City of Halifax is privileged in having a full time Child Guidance Clinic whose triple function is described as: service, teaching and training. Some evaluations are done through the Halifax Children's Hospital, but no in-patient facilities are provided there. Psychotic children are admitted to the Provincial Mental Hospital: no separate facilities are provided for such cases.

Dalhousie University in its training scheme for residents requires that they spend a certain minimum of time in child psychiatric settings. Formal courses in child psychiatry have been established this year providing more specialized

[1]Staff psychiatrist: The Mental Hygiene Institute, McGill University; Staff psychiatrist: Ste Justine Hospital, Montreal.

training as an option in the last years of the general post-graduate curriculum.

Prince Edward Island:

For its relatively limited population, Prince Edward Island is privileged not only among the Maritime Provinces but even when compared with other areas in the country. It boasts of having no waiting list for children in need of psychotherapy, and of carrying out special programs and research in the field of Mental Retardation.

In Charlottetown, most of the work done at the Mental Health Clinic concerns children. The staff consists of a full-time psychiatrist, a full-time psychologist and a half-time social worker. A travelling clinic (one day a week) will be operating regularly upon return of 6 social workers now in training.

With the addition of one half-time child psychiatrist, and a few ancillary workers (special teachers, etc.), the program would be considered adequate for the population, a unique situation indeed.

Quebec:

Of the two cities with medical training facilities in this province, only one is really active in the field of child psychiatry. The other, Quebec City (Laval University), has only one child psychiatrist and he is involved for half of his time with adult patients. There is, however, a child out-patient clinic (Centre Médico-Social pour Enfants) where 400 new cases are seen each year. An undetermined number are taken in treatment. The staff includes two part-time psychiatrists, one part-time pediatrician, three full-time psychologists, three social workers, two psychiatric nurses and the clerical staff. A Mental Health Clinic for children operates in a General Hospital (about 350 consultations in a year). Training is of course unavailable except for short stages in the above-mentioned clinics for post-graduate students in general psychiatry.

Montreal is favoured with three centres of child psychiatry. Two are affiliated with McGill University: The Montreal Children's Hospital Department of Psychiatry and the Mental Hygiene Institute; and the third, Ste Justine's Hospital Department of Psychiatry, is affiliated with the University of Montreal. Many other resources exist in Metropolitan Montreal which cater at different levels to emotionally disturbed children: societies for retarded or emotionally disturbed children are presently very active in implementing educational and rehabilitation facilities. Also a special emphasis is placed on family dynamics at the Jewish General Hospital; and some privately owned institutions offer residential treatment (usually with insufficient staff) to small numbers of privileged children.

Sainte-Justine's Hospital Department of Psychiatry is the nucleus of child psychiatry for the French-speaking population of the whole province. Its structure has changed very little since it was described by its Director, Dr. Denis Lazure, in an earlier issue of this Journal (CPAJ *4*: pp. 176-181; 1959). At present its staff complement is – 7 child psychiatrists (3 full-time, 3 part-time, one consultant), 3 residents in training, 5 psychologists, 5 social workers, child-care workers, nurses etc. The current case-load is around 150 in treatment. Well over a thousand children are seen each year in screening, consultation or guidance processes. Since the hospital caters to distant regions of the province, many patients are seen only for an assessment or for the purpose of recommending special dispositions. Training of one year for post-graduate residents offers a comprehensive experience of child psychiatry with an adequate program of lectures, seminars and supervision. Again, in the French-speaking community, several agencies and institutions with (but more often without) the help of professional supervision, harbour and try to rehabilitate hundreds of mentally or emotionally disturbed children. Strangely enough, however, the problem of delinquency is deliberately kept out of

reach of the medical profession by the government authorities.

The Montreal Children's Hospital Department of Psychiatry operates at various levels. Its total contacts number over 2000 cases per year. Psychotherapy is provided through an out-patient clinic. Consultation services are offered to other departments in the hospital as well as in the pediatric out-patient department. A day-treatment centre accepts groups of psychotic children for 3-5 half-days a week. The Mental Assessment and child guidance clinic processes over 300 diagnostic problems each year: it focuses on problems of mental retardation. Since 1959 a ward for on-going observation and limited attempt at treatment of selected cases has been in operation: its capacity is 14 in-patients with 3-4 day-patients added. Well implemented departments of psychology and social work function in parallel, but actually contribute largely to the diagnostic and treatment schedules.

Staff consists of 5 full-time and 3 part-time psychiatrists. This year, 11 residents (4 in second year) are in training as part of the McGill post-graduate diploma course in psychiatry. The Department has recently been recognized and accredited for two years in the post-graduate curriculum.

The Mental Hygiene Institute offers consultative services to various agencies, several of which deal with children. Psychological and psychiatric services are available to other professionals working with children in institutions, courts, foster homes or schools. The Staff consists of two full-time and three part-time psychiatrists, two psychologists and one resident in psychiatry.

Ontario:

The University of Toronto offers a well diversified teaching and training program, with the opportunity for experience in hospital settings (Toronto Psychiatric Hospital, Hospital for Sick Children, Thistletown Mental Hospital for children), community clinics, schools, Juvenile Court and children's agencies. A six month experience in Child Psychiatry is offered to residents in the second year of the course in general psychiatry. Also, since July 1960, the third and fourth year program may be spent in Child Psychiatry for those who wish to specialize in this field.

Across the province Mental Health Clinics (along the traditional pattern: psychiatrist, psychologist, social worker) cater to children in varying proportions, depending on the staff available and other facilities in the area. Most of these are directly operated by the provincial government or attached to branches of the Ontario Hospital.

More specialized are Smiths Falls (2300 mentally retarded; 35 psychotics), a Day-Care centre (Cobourg Ontario Hospital: about 55 cases last year), and a recently opened Child Guidance Clinic (London: limited intake and special research interest). Finally, Hospital Departments at the Ottawa General Hospital, St. Catharines General Hospital, etc., provide comprehensive diagnostic and treatment facilities short of residential care.

The University of Ottawa, Queen's University and University of Western Ontario reported no special training program in Child Psychiatry.

Manitoba:

Most of the facilities in this province are grouped around Metropolitan Winnipeg. At Selkirk and Brandon children are seen in adult psychiatric facilities. However, province-wide services for pre-school and school age children are in the planning stage. There is a school for Mental Defectives in Portage-la-Prairie.

In Winnipeg, there is no child psychiatrist in full-time private practice. Children are seen privately by psychiatrists in the general practice of psychiatry, as well as by child psychiatrists with University Hospital and Clinic appointments. Referrals are made to the Children's Hospital where diagnosis and treatment

services for both in and out-patients are provided. A limited number of psychiatric patients are admitted to the medical ward. Plans for expanding into a fifteen-bed psychiatric ward, and a twenty-bed longer term (one to two years) residential psychiatric treatment unit are being studied. A pre-school Child Development Clinic (in association with the out-patient department of the Children's Hospital and the Public Health service) would provide ambulant services, as well as opportunities for teaching and research.

Finally, the Child Guidance Clinic of Greater Winnipeg jointly financed by the Provincial Department of Health and local school districts provides comprehensive service through its five departments (psychiatry, psychology, social work, reading, speech and hearing) to any child attending public, private or parochial schools in the area served.

As part of their post-graduate training in psychiatry, three residents in the third year divide their time between the Children's Hospital and the Child Guidance Clinic of Greater Winnipeg. They perform diagnostic examinations and conduct long and short term psychotherapy under supervision. Seminars, lectures, group supervision and collaborative treatment conferences are conducted by hospital and clinic staff psychiatrists.

Saskatchewan:

As in many other areas, services and facilities for children here are not separated from those offered to adults. In mental hospitals a very small number of psychotic children are admitted each year and placed on adult wards. A training school for the mentally retarded has no special facilities for emotionally disturbed children, although many of the admissions fall into this category. There are three general hospitals with psychiatric in-patient departments where children are placed on general pediatric or adult psychiatric wards. Admission is generally of an average of two months for diagnosis and treatment. The latter includes physical methods, individual psychotherapy and occupational therapy with some remedial education. (In 1958 the three units provided service for a total of 45 children).

In addition, several out-patient clinics throughout the province, functioning on a full-time or part-time basis offer facilities for the diagnosis and treatment of emotionally disturbed children. Only two psychiatrists are involved full-time working with children. The largest percentage of children seen in any of the clinics in 1960 was 63%. One of the main reasons for referrals is considered to be learning and reading disability. This particular area has become a project for research and special techniques have been developed which are currently being tested. There are also two residential treatment centres for male and female delinquents: both are oriented towards group milieu therapy and provide psychological and psychiatric consultative services.

Alberta:

A Child Guidance Clinic located in Edmonton is staffed by two full-time psychiatrists, six psychologists and six social workers. It provides a travelling clinic service to some ten rural points on the basis of one day every two months, and into farther removed areas on the basis of one to six days per year. Primarily however it provides treatment for cases in the city of Edmonton and its vicinity. There are also full-time services in the cities of Calgary and Lethbridge, and a part-time service in the city of Medicine Hat. These clinics are not limited to children, but they constitute 75% to 80% of their case-load.

A small eight bed residential unit in the University Hospital admits children for periods of observation and treatment up to six weeks. A residential treatment centre with a capacity of 22 has been functioning for about a year on the grounds of the Provincial training school at Red Deer. Another residential treat-

ment unit in Edmonton is ready for construction.

The Provincial Guidance Clinic in Edmonton has been accredited by the Royal College of Canada for one year of post-graduate training and will start taking residents this year.

British Columbia:

The Division of Mental Hygiene of the Metropolitan Health Committee in Vancouver covers the whole school population, and has seen, for instance, 428 cases referred in 1959. It is a city institution and referrals are accepted from all sources. There are nine contributing areas in Vancouver. Over 100 cases may be treated at the clinic, while others are directed to outside facilities or supervised at home by Public Health Nurses. The staff consists of two psychiatrists, four psychologists, five social workers and 150 Public Health Nurses. A recent concern and work project has been the problem of school failures in adolescents.

In Burnaby, a Mental Health Centre has separate facilities for adults and children. It is part of a Provincial Mental Health service. It offers direct service: where the clinic assumes the responsibility for diagnosis and treatment; and consultative service: where other agencies request assistance but retain responsibility of the referral. In this latter category there is also a travelling clinic service which involves a psychiatrist, a social worker and one or two psychologists, visiting centres throughout the province. The direct service has usually about 100 cases active at any given time. These are carried at the rate of once or twice a week, and duration of treatment varies from a few months to a few years. The emphasis is on treatment of the whole family. There is also a day-treatment centre serving two groups of about eight pre-school children. These are seen five times weekly.

Another provincial institution in New Westminster is Woodlands School for the mentally retarded. The professional staff consists of a pediatrician experienced in mental health, a psychologist and a social worker. (No information as to size, or nature of treatment was given). In Vancouver, a private agency, The Esther Irwin Home, is a therapeutically controlled residential setting for emotionally disturbed boys and girls from six to twelve years of age. Average time for treatment varies from four months to two years. Referrals are accepted from various sources, private and otherwise, and close contact is maintained with agencies, parents and community. The staff consists at present of a psychiatrist who treats each individual child and supervises the total program, a group worker, three teachers and six child-care workers. There are 13 children in residence at present and a waiting list of referrals is growing constantly.

Also in Vancouver the Children's Aid Society who has in care from 1200 to 1300 children between the ages of two weeks and 21 years is engaged in psychologically oriented child placement. It is helped in this by a consultant psychiatrist and a psychologist who interview children, families and foster parents in order to ensure an appropriate placement.

Training facilities in this province are still in the planning stage.

Concluding Remarks

It is plain to see that child psychiatry in Canada has not yet reached maturity. Few areas are reasonably satisfied with their present programs and facilities. Even in the most advanced and better staffed university centres systematic training is merely beginning. Some of the minimal requirements of any child-care program are clearly deficient: adolescents are practically forgotten everywhere, and long-term treatment centres are scarce. Even specialized institutions for the placement of chronic patients, of reasonable size, with reasonable complements of staff and some attempts (at

least) at symptomatic treatment, are practically non-existent.

Obviously the needs far outrun the growing facilities. and this may generate a new kind of problem. Public services and community resources, rightly alarmed by the situation, have already in some areas procured solutions of their own outside the scope of Child Psychiatry. Such movements, in spite of their immediate usefulness, are self-limiting in their action, and often oppose other efforts on the part of bona-fide psychiatric centres. Moreover, considerable sums of money are spent in haphazard ways, and are lost to painfully striving training and research institutions.

I would venture to suggest as careful and systematic as possible an evaluation of regional as well as nation-wide needs[1] for Child Psychiatry, now, while most areas are still in the planning stage. This could save years of trial and error and help avoid the misappropriation of staff and resources.

Summary

A brief outline[2] of child psychiatric facilities in each of the 10 provinces was gathered with the help of the corresponding members of the Nucleus Committee on Child Psychiatry. Some of the outstanding facts are underlined and the suggestion of a systematic survey of the needs for Child Psychiatry is made.

[1]For instance along the lines of the Canadian Mental Health Association survey in P.E.I. (in progress).
[2]More detailed information may be obtained from the Committee, Dr. T. Statten, president: The Montreal Children's Hospital, Department of Psychiatry, Montreal.

Résumé

La pédopsychiatrie au Canada n'a pas encore atteint l'âge adulte. Dans quelques centres universitaires l'émergence de programmes spécialisés laisse espérer une croissance accélérée et un essaimage vers les régions moins fortunées. Certaines lacunes cependant demeurent inexplicables: la pénurie par exemple d'hôpitaux psychiatriques (ou de services distincts) de séjour permanent ou semi-permanent, la quasi-absence de centres résidentiels de traitement de durée moyenne (sinon, et encore très peu, à l'échelle privée). Les adolescents sont complètement négligés; ils dépassent les normes et les techniques de la psychiatrie infantile proprement dite et malheureusement présentent des problèmes que le psychiatre d'adultes ne veut pas aborder.

A coup sûr, il est difficile de déterminer les besoins de chaque région et encore plus de suggérer des standards et le moyen de les atteindre. Certains besoins sont évidents, et il n'y a pas de raison que dans l'essor de la psychiatrie et l'évolution des programmes de santé mentale la part des enfants soit reléguée au second plan. Après tout il est logique de considérer tout effort dans ce sens comme une saine politique de prévention.

On ne peut s'empêcher de reconnaître qu'il serait souhaitable, pendant que la psychiatrie infantile cherche encore ses moyens, d'étudier les besoins de notre population dans ce domaine de façon systématique (à l'échelle locale comme à l'échelle nationale), afin d'éviter les retards, le dédoublement et les multiples erreurs qui naissent d'efforts spontanés mais mal éclairés.

PERCEPTUAL ORGANIZATION IN INFANCY AND CHILDHOOD*

DANIEL CAPPON, M.B.[1]

The purpose of this paper is to summarize the scattered work done by others on the development and organization of perception, to ask some questions in this area, and suggest reasons why answers might be crucial to Psychiatry.

Charles Osgood defines perception as a set of variables intervening between sensory stimulation and awareness. Floyd Allport said of percepts "In them . . . lie the essentials of our present knowledge of one of the most important activities of living beings". Clearly, perception is the corner stone of the mind. It is the pristine mental function by means of which any change whatsoever has its psychological effect on the person.

Classification. The ordering is in descending scale of reliance on direct mediation by sensory pathways (sense data); increasing scale of physical to psychic organization, and hence increasing need for closure.

1. Modality percepts – depend directly on extero- and interoceptive data and pathways whose receptors are divisible into a) distal: visual, auditory and olfactory, and b) proximal or on the body: gustatory, tactile (including temperature), proprioceptive, kinaesthetic and visceral.

2. Orientational percepts–depend more indirectly on sense data and require higher integration at the body-becoming-mind level. Arranged according to increasing order, they are:

1) Movement and size of objects in relation to the body.

2) Body boundaries, movement and weight.

3) External space.

4) Time which includes the more (a) subjective percepts of (i) time passage, by sequence of events, and (ii) subjective notions of temporal localization, sense of pastness and futureness, and (b) the more objective percepts of (i) estimate of short and long, filled and unfilled, chronological time intervals, and (ii) temporal localization (when?), pastness (sequence of events), sinceness (how long ago?), and futureness (when in the future?).

3. Introspective percepts – depending even more indirectly on sense data, on high level psychological organization needing large closure. These inform the person of his own emotions, thoughts and behaviour.

The remainder of this paper is to be concerned specifically with orientational percepts because they appear to be of primary importance to Psychiatry.

Literature. What information is available from which field of knowledge to help outline the development and organization of orientational percepts? More precisely:

1) In what relation to each other, to somatic maturation, and social, psychologic and dynamic contexts, do orientational percepts develop?

2) When do they reach maturity?

3) What are the determinants of their development?

4) Therefore, what hazards occurring when, during development, would have what consequence?

Neuro-anatomy, histology and cytology. The perception of the body in space depends on afferent impulses from:

1. the retinae – supplying visual spatial orientation.

*Paper given to the Child Psychiatry Section at the Annual Meeting of the Canadian Psychiatric Association on Thursday, June 16, 1960.

[1]From the Section of Research in Psychodynamics and Psychopathology, Department of Psychiatry, University of Toronto.

2. the proprioceptors of ocular muscles – for distance and direction.
3. the labyrinth and the semicircular canals – supplying kinetic spatial orientation.
4. the otoliths – for gravity sensation.
5. the proprioceptors of the joints and muscles of the neck – for head position.
6. the proprioceptors of the lower limbs and trunk – for body position.
7. all the sense organs.
8. the central mechanisms and connections of the cerebellum, vestibular nuclei, posterior longitudinal bundle and red nuclei.

Final integration of spatial, object and body percepts takes place in the cerebral cortex – mainly the temporo-parietal lobes. The percept of time probably requires all the above listed pathways, and also the totality of cortical integration – the silent areas storing memories and the frontal lobes in particular. We know from lobotomy procedures that 'futureness' and other aspects of a time sense, essential for instance in planning, are impaired, often grossly. Awareness and arousal have, in addition, two great cerebral systems as a substratum: I. the reticular activating system,–i.e. the midbrain reticular formation, thalamic and cortical projection, and II. the Papez circuit–i.e. hippocampus, amygdala, fornix, mammilary bodies, cingulate gyri and cortical projections.

Nervous impulses are said not to be conducted until myelination is completed. Myelination begins in the 8th month of intrauterine life and it does not end until the 18th year or even later. Myelination according to Fleshing begins with the afferents to the postcentral gyrus and hippocampal areas and spreads to the visual and auditory sensory cortical areas. By the 3rd month postnatally, the great efferent cerebrospinal pathway begins to acquire its medullary sheath and by 18 months this is completed. At this point the average child vaguely appreciates the present, phantasies and hallucinates the future, and has no sense of the past but appreciates depth in space. The visual and auditory psychic areas do not begin to myelinate until the 6th-8th month, therefore visual and auditory memory cannot exist and acts are hardly voluntary. Myelination ends with the fibres of the large association areas (frontal, parietal and temporal). There is much individual variation. Although the times given are conservative and tracts are invested with myelin earlier, the sheaths grow thicker and thicker and it is not easy to say at what point the function is fully developed. Langworthy and Minkowski suggested that some function is possible without myelin. Langworthy went so far as to state that myelination develops as a result of function – certainly activity accelerates it.

But maturation does not depend on myelination alone. The cells of the cortex are immature, Nissl granules sparse until after birth. Cerebroarchitectonics would have to await the completion of the tours-de-force in which J. LeRoy Conel is painstakingly describing the development of the human cortex (according to width, cell number, size of layer, chromophil condition, neurofibrils, compactness of cells, pedunculated bulbs, size and number of exogenous fibres and myelination) area by area in 3 monthly postnatal periods. She has barely reached the second year. Then there is the work of correlating all this – for instance activity of growth in the temporal lobes or cingulate gyri – with function in general and with acquisition of percepts in particular.

Neurophysiology. The reflexes of Magnus for posture and equilibrium are present soon after birth. The tonic neck, righting, otolith and Landau-reflexes are all present. Responses to movement and acceleration, the Sprungbereitschaft are also ready then. Sensibility to pain and temperature is present and soon becomes acute. Light is soon perceived and hear-

ing responses occur in a couple of days. By the 2nd month, the head will turn to the sound and the eyes will follow. By the 4th month tonic reactions are present with the head being held up; by the 6th, visual and auditory discrimination is advanced. Not until the 5th year, however, are the reflexes, galvanic irritability of muscles and modality perception formed in adult patterns. At this stage the average child has 3 tenses to his verbs and may distinguish the days of the week.

E.E.G. studies show that hemisphere symmetry and synchrony are not quite achieved by the 3rd year. The temporal region, so important for orientational percepts integration, matures last. Sleep spindles begin to be expressed strongly at 3-4 months and gain adult form by about the 30th month. The fast E.E.G. activity of early childhood settles down by 7 years or so. By then the average child's notions of temporality are less egocentric. He appreciates chronological time apart from himself and also begins to perceive Euclidian space. The hypnogogic state – which may be a very feathery pillow of perceptual distortions – may show paroxysmal bursts of high voltage all the way from 30 months to 10 or 11 years. The E.E.G. of arousal shows even more clearly that maturation slowly reaches a peak as late as at 12-14 years. Only now may the child have a complete perception of the continuity of time and space reaching the extremes of the span.

Head and Holmes, Paul Schilder and Lhermitte, are the authors of classical descriptions of the adult body schema, but unfortunately no one appears to have described its development; nor its correlation with other functions of perception.

Child Development. The ability to converge on nearby objects, such as the infant's own hands, must be the visual commencement of body imagery as well as the 'sensory motor phase' for space depth perception. It happens at 3-4 months. As stated elsewhere, about the incipient relationship between body imagery and the self "it all begins with the pleasure of textures soothing to the skin; of appetizing odors and the sight of the roundness of the breast; with the joy of freely kicking heels; the pride of muscular feats, the contentment of orificial satiety and the release of orificial tension; the contemplation of the belly button in the manner of the Buddha and the victory of the prehensible actions of the toes and fingers". By 18 months, the child commands the vertical dimension, by 3 years the horizontal; at 5 he can draw a triangle. Thus he masters shape and dimension of external objects. Piaget in France, and Anthony, now in North America, have done a great deal to direct attention to the development of object relationships. The body, as Szasz agrees, is also part of the objective world of the child. Orientational percepts form the background or matrix for object relationship – giving them vital dimensions. Perhaps in the first 9 months objects have no fixity – thereafter memory aids in a search for objects hidden in space. By 2 years, the 'sensory-motor apparatus' is ordered in time and space. Constancy of size, shape and colour are recognized. The child, after mother's countless tries, recognizes itself in the mirror. At the end of this phase of cognitive orientation, a cathectic orientation begins when the child, having passed an animistic phase of ascribing life to inanimate objects, can discriminate his outside-self and his inside self (see Klein's internalized objects) from outside objects to which he can relate. At a point, past the proto and parataxic phases, language becomes syntactic and this coincides with a realization of conservation of matter, weight and volume. By now (7-8 years) spatial perception has reached what Brain and Pötzl call its final task – the recognition of an absolute three dimensional space by the creation of invariants so that the identity of (visual) objects is maintained independently of the relation system in which they are at the moment arranged.

Beyond this, the Universe is at least Euclidian until it becomes Einsteinian. Then the child can think non-autistically.

Clinical Psychology. Despite its periodic interest in perceptual tests, has not contributed directly to our problem. It has long been recognized that on the tests devised (which are obviously insufficient and not fully saturated with orientational percepts) the sexes differ in ability and there is a change with age, in say spatial discrimination. Though adult clinical psychology has clearly demonstrated that perception in emotional and mental illness differs, often radically, from the norm, no ontogenic study appears to have been carried out to show how this comes about.

Experimental Psychology and Psychiatry – have been most helpful in supplying facts. It has been suggested, for instance, that the periodicity of experience of sleep and wakefulness, after the first 3 weeks of an undifferentiated phase, may initiate the ordering of lapses and durations in the percept of time. The same may be said of appetities with such periodic activity as hunger and satiety.

More importantly, work on sleep deprivation and diminished and increased sensory variability, psychotomimetic drugs, etc., suggest that orientational percepts regularly become affected, that concommitant emotional reactions increase orientational distortions, that modality changes: visual hallucinations in the so-called "model psychosis" rather than auditory ones – are idiosyncratic and depend, in part perhaps on a sensory typology; and that thinking 'disorders' follow orientational perceptual changes.

Ethology – One can hardly close this subject without briefly bringing into focus the relevance of imprinting and critical periods at least on animal if not on human perception. The chick, for instance, imprints the parental object in the first day, the spatial surroundings the second day, and food objects the third day. This makes teleological sense. Sensory deprivation in young animals as in adult humans induces perceptual disorientation. This may last permanently, depending on the age or 'critical period' of induction of change and also on the degree of domestication of the animal. The wilder the animal, the faster and more irreversible the imprint. It is likely, therefore, that even in the not so domesticated human infant, imprinting as such may not occur, but optimal periods for the acquisition or distortion of orientational percepts, may occur.

Psychoanalysis – has made spotty contributions to this subject. The Balints have written speculatively on a person's relationship to space. They describe the acnophil who clings to terrestrial objects and is fearful of vertiginogenic, weightless, space adventures, and the philobat, who is spatially adventurous.

Experimental and Clinical Paediatric Psychiatry – Literature is concerned with the importance of parental objects and of love ties in the development of perception in particular and behavior in general. Harlow, Bowlby, Spitz and others have demonstrated with animals and humans respectively, clinically and experimentally, the fact that if parental and love relations are disturbed all behavior changes. If the findings of ethology is transposed to humans, in the context of disturbed parental and love tie relationships, orientational percepts would suffer early in development – and there might be irreversible damage.

It is noticeable that very little, if any work has been done on the sense of gravity or weight, the sense of movement of the body, movement of objects in relation to the body, or even boundary of the body in space. Certainly none that could be found on the molar relations of the development of one orientational percept in relation to the others.

Discussion. These scattered bits of information have led to a loose system of ideas, a heuristic theory of abnormal behavior.

It was felt that orientational percept change might play a key role in mental illness in the following way: If, during childhood, when perceptual function is immature and fluctuating, a person is exposed to conditions inducing orientational percept change (immobilization, operations, severe anxiety) or conditions interfering with proper development of orientational perception (disruptive mother-child relationship leading to faulty child-object relationship) it is possible that orientational perception is subsequently susceptible to change or distortion. This in effect would set the stage for a vicious circle in which orientational distortion would occur more and more frequently with a concurrent widening of the gap between awareness and reality. In such a state, there would be an urgent need for "explanation" to the self for these happenings which might be expressed in terms of a fear of loss of identity and self or a terror of non-being. Ideas might then emerge as explanations which would appear appropriate to the person but inappropriate to the observer as indeed might much of the person's behavior. This picture seems to provide the common core of many psychiatric syndromes – lack of contact with reality, inappropriate beliefs, ideas and behavior and strange fears.

This would lead to the following questions being asked of child psychiatry: Do traumata of development such as hospitalism, the experience of separation from parent-objects or hurt to the body-object by injury, disease or operation in infancy and early childhood; the experience of being handled by a postpartum psychotic mother and early deprivation in general, operate significantly in later life, only if they occurred originally before orientational percepts have reached a certain stage of maturation? Could it be that once the senses of time, space, body and objects in space are malformed a proper objective frame of reference might never emerge – thinking would remain autistic, feelings endogenous and outer reality easily clouded over with sensations ranging from dizziness (spatial disorientation) and light-headedness or floating feelings (body weight disorientation) to unreality variously interpreted for the communication of complaints to the self and to others? The autistic child ought to be a walking laboratory for such studies.

In respect to education, Blake said "If the doors of perception were cleansed, everything would be as it is – infinite". There is a good chance that much of what we call education clogs them. Probably, no reasoned learning can take place much before the maturation of orientational percepts for two reasons: Firstly until the objective assessment of time, space, body boundaries, weight and external objects are differentiated by development from the nebulously subjective feelings about these dimensions, until, that is, the self finds its place in universal concourse, no logical thinking is possible. Secondly, it is suggested that the birth of continuous memory is coincidental with a peak in the maturation of orientational percepts. With more attention to the development and functioning of orientational percepts, it may be that testing the readiness for intellectual learning and speeding up the learning process would be possible.

Résumé

L'auteur définit la perception, selon Osgood, comme un groupe de variables qui agissent entre la stimulation sensorielle et la conscience. Divers modes de perception sont ensuite énumérés. L'état de la question, selon les travaux les plus avancés, est ensuite discuté du point de vue de la neuro-anatomie, de la physiologie, du développement de l'enfant, de la psychologie clinique et expérimentale, de la psychiatrie adulte et infantile. Chacune de ces disciplines apporte des données sur l'organisation des perceptions spatiales. L'auteur discute enfin, à la lumière des faits ainsi rassemblés, une théorie psychanalytique du comportement plus compréhensive, de même que certains aspects de la psychiatrie infantile et de l'éducation.

REFLECTIONS ON THE ROLE OF THE MOTHER IN THE DEVELOPMENT OF LANGUAGE IN THE SCHIZOPHRENIC CHILD*

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The problem of communication in childhood schizophrenia is fundamental. It is related to aetiology, for the early disturbances in the relationship of mother and child, as reported by most mothers of schizophrenic children, are a problem of communication. Communication is also basic in the psychotherapeutic treatment of these children, because the great stumbling block to psychotherapy is the inability of even the most experienced therapist to understand and communicate in a constant manner with the schizophrenic child.

Before proceeding further we would like to explain what is meant, in the present context, by a schizophrenic child. Whatever the syndrome such a child presents, syndrome which can make him appear either autistic, symbiotic or atypical, it is always characterized by a severe ego disturbance as regards the adaptation to reality and the capacity to communicate with his milieu. The study of ego disturbances in the perspective of the mother-child relation is in line with a long history of such studies made in the field of genetic psychology and psychopathology.

The mother is the first object who satisfies the drives. Not all mothers can satisfy or permit the expression of all the drives of their child. Our own experience with schizophrenic children and their mothers indicated to us that the mother has most often been a satisfying object of erotic drives, very seldom a rejecting mother and quite often an over-indulging mother. Somehow she has failed in helping to build the ego of her child.

Why is it so? Despite apparent personality differences in the mothers of schizophrenic children, we feel that there is a common dynamic core of severe anxiety regarding the management of aggressive impulses either in themselves or in their child. It is the transformation of aggressive drives which is probably decisive in the formation of the ego (1, 2, 3). "Satisfaction of partial drives are not sufficient to build a strong ego: . . . but also that so called "good" object relations may become a developmental handicap – probably, I should think, if and in so far as the child has not succeeded in utilizing them for the strengthening of his ego. . . . That is, "satisfactory object relation" can only be assessed if we also consider what it means in terms of ego development." (4, p. 15).

It is our feeling that the mothers of schizophrenic children have been and are still a satisfying object of some partial drives. They, however, have failed, because of some ego deficiencies of their own, to be an ally to the child in regard to the intensity of its aggressive instincts. They have been unable to lessen the tension of the child and foster in it the neutralization of its aggressive energies.

An infant's demands upon a mother are exacting and tyrannical. These demands are forced upon an adult who has struggled for many years to establish a control over her needs, to learn to postpone gratification in accordance with reality. The infant with its primitive needs, the use of its muscular system as a medium of communication, re-awakens in the mother old conflicts or initiates

*This article is based on a paper presented at the ACFAS Congress in Ottawa, October 1958. This article is based on the intensive study of 9 cases of schizophrenic children and their mothers treated at the Nursery of the Psychiatry Department of the Montreal Children's Hospital, with the collaboration of psychiatric social workers, especially Miss Jessie Waters. The ages of these children ranged from three years to nine years. They were treated for a period of one year to four years.

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new ones, especially around aggressive impulses.

We cannot discuss here the vicissitudes of the aggressive drives, but may we mention that these vicissitudes are in great part determined by the more or less free use they can make of the motor apparatus and also by their acceptance and rejection by the milieu. The new-born infant is nearly all motricity and as Bühler remarked, a motricity of a rather negative nature (5). Even in a normal situation, this is sufficient to lead to an inter-play of child-mother aggression, which is going to reveal itself, on the part of the mother, in the way she handles her child. "The mother has the upper hand in determining the kind of behavior on the part of the infant she will accept or encourage." (6, p. 239). Also as Hendrick (7) mentions, the mother's way of doing certain things rather than her prohibitions, is going to be decisive in the formation of the child's ego identifications.

The importance of the first adult in the early development of object relations and identifications is the cornerstone of psychoanalytic theory, but the importance of this adult is also stressed in the field of communication. "In early infancy, the child is dependent upon the muscular assistance of the adult. The incomplete and undifferentiated movements of the child are interpreted and completed by his parents; a crying baby, as if he has pushed a button, sets a whole machinery of adult help in motion. Conversely, the adult creates situations in which the infant can practice his limited movements." (8, p. 17).

Communication between mother and child exists before the appearance of verbal language. The first communications are through the medium of the muscular systems of both partners. The infant expresses its needs through its muscles, i.e., crying, kicking, rages, but it also expects a feedback on the same level. It expects to receive from the mother handling, feeding, toileting, singing, cooing and so on. This interaction is not only need-satisfying or tension-relieving, but: "This path of discharge acquires an extremely important secondary function – viz., of bringing about an *understanding with other people*; and the original helplessness of human beings is thus the primal source of all moral motives." (9, p. 5).

The early handling of the child by the mother is going to lay ground for its future identifications; but the mother's own capacity to identify with the child, meaning to understand her child, is going to be decisive in establishing communication between them and eventually in the development of language. Identification has been mainly studied from the point of view of the child but what about the capacity of the parent to identify with the child? "We may note here that few of us are aware of the fact that it is not only the child who imitates the grown-up, but that the obverse is also the case. This is a phenomenon which, to my knowledge, has never been investigated either in its general or in its specific aspect. Yet it plays a significant role in the formation and development of object relations both from the viewpoint of the parent and from that of the child." (9, p. 41).

Nevertheless, the capacity to identify with the child is not sufficient in itself, it has to be of a flexible nature. The mother must be able to shift from one level of identification to another, when the child is ready for such a move. Balint remarks: "Maternal love is the almost perfect counterpart to the love for the mother" (10, p. 256). Infant and mother fill each other's needs. This exchange will vary in quality and intensity depending on the child's state of growth. The ideal mother is the one who can identify with the needs of her child at each phase, but also can accept that the needs may change in intensity or may require to be gratified through different means. Love for the mother, as well as the love of the mother for the child, is during the first months of the life of the infant, instinctual, narcissistic, governed by the pleasure prin-

ciple; gradually, as mother and child fight to see each other as two different individuals, by introducing more and more of the external world in their relationship, love for the mother and motherly love become more rational, more altruistic and governed by reality principle. Capacity to identify with the infant and flexibility in identifying at different levels of development are essential to insure communication between mother and child.

In the mothers of schizophrenic children, the arrival of that particular child (for very specific reasons) threatens an already unstable equilibrium in regard to their own identification and in regard to the easiness with which they can permit their identifications with the child to be governed by the pleasure principle or the reality principle. Dependency upon one or the other of these two principles is usually observed or understood in the terms of either over-indulging primitive gratifications or prematurely forcing the child to adapt itself to a reality, at a time when it is unable to do so. From the point of view of communication, to yield to the pleasure principle in dealing with an infant, is to favour modes of communication which are determined by primary processes, mainly non-verbal forms of communication. To yield to the reality principle is to favor modes of communication which are determined by secondary processes, mainly verbal forms of communication. Neither is pathological in itself. Difficulties can arise when a mother is unable to use forms of communication which are appropriate to her child's age or when she is unable to shift to one form of communication to another one, according to circumstances.

In the course of our work with schizophrenic children, we were struck by certain differences between the mothers whose children possessed no speech at all or very little speech and the mothers of children who possessed speech but used it in a bizarre, distorted fashion.

The first group of mothers struck us as being over-dependent on the reality principle. They often appeared at first contact as rather well adjusted individuals, able to deal with their other children, managing their housework chores and very often, playing an active role in their communities. Intensive contacts with them showed that they always felt very uncomfortable with their own inner life, especially in regard to their aggressive impulses. They had succeeded in establishing a certain control through the help of obsessive-compulsive defences, which were reinforced at the arrival of the child. Because of its uncontrollable demands, the child was identified with their own instinctual life. These mothers became slaves to external reality, they became very ritualistic regarding feeding procedures, rigid in regard to toilet training and being afraid of spoiling their child, they enjoyed very little contact with their infant. The function of mothering lost its adaptive characteristic to become defensive. For them, the crying of a baby was not felt as a warning signal to be investigated, but rather as a disturbing element which one had to alleviate as soon as possible, by any means. These mothers, very early on, preferred to use verbal language rather than physical contacts and gestures, and this during a period of the child's life when he was completely immune to verbal communication. Communication with the child was not intended to bring a mutual understanding but rather, as a means to make the child agree to their own demands. The child withdrew more and more and became completely uncommunicative even on a non-verbal level: it did not smile, it did not enjoy hugging and it was perfectly satisfied to stay by itself for long hours. It did not learn to speak and if it did, the few words were usually the mechanical repetitions of the mother's prohibitions. This type of child is often brought to the clinic at an early age when it usually presents the picture of the autistic child described by Kanner. The mother's main complaint is the child's

inability to learn to speak and very often she suspects deafness.

The second group of mothers struck us as being over-dependent on the pleasure principle. They always had very weak ties with reality as shown by their passivity, their lack of social interests and their many somatic symptoms. Contrary to the first group, they often appeared on first contact more anxious, more immature and more disturbed. The birth of a child was an excuse to reinforce their social withdrawal, they lost whatever sense they had of their own identity, they were going to live through their child. These mothers submitted easily to the child's needs, they favored prolonged exchange through physical contacts. They prevented the child from forming any ties with other adults, and in some cases, the child was never left even with the father. Contrary to the mothers of the first group, the anxiety over their own aggression was not manifested during the first months of the child but rather later on, when the time came when they had to impose frustrations. They were unable to do so, because for them to frustrate the child was to be aggressive. The child learned to speak, but its language remained an individualized and distorted one; it was not reality oriented but id oriented; it was going to remain a magic language where the word and the thing were still fused. Very often mother and child understood each other very well and the child was brought to the clinic only when reality forced itself on the mother-child unit and the latter could not be integrated in the community schools. The picture this child presented was similar to the one described by Mahler as the symbiotic child.

It would seem from these observations, that the mother's dependency on reality principle and her preference for verbal forms of communication or her dependency on the pleasure principle and her preference for non-verbal forms of communication, have some influence on the child's development of speech. We cannot discuss at length the effect that such an hypothesis could have in the psychotherapy of the mother and of the child. The often repeated statement that a psychotic child with language offers a better prognosis than the psychotic child with no language, can be misleading. It is not the language itself which is of positive help in the psychotherapy, but rather its presence implies that there has been a satisfactory communication between mother and child at the non-verbal level of communication. The presence of language in a psychotic child can be detrimental to the psychotherapeutic process itself, at least at the beginning. The therapist easily succumbs to the temptation of using words in communicating with the speaking schizophrenic child, forgetting that though they both use words, they do not have the same meaning for the therapist as for the child. For the latter, words are governed by primary processes, for the former words are governed by secondary processes. Non-verbal forms of communication through contacts, gestures, noises, games, are the best tools of understanding and communication with psychotic children, at least during the long initial phase of psychotherapy.

Neither can we discuss at length the complex processes involved in this identification, by the child, with one aspect of the mother's behavior, her language. In the case of the child who acquires language, identification seems obvious. Also in the case of the child who does not develop language, identification is also at stake. In this case the identification is made probably with the aggressor, and probably only with certain aspects of the aggressor's behavior, the negative effect underlying the mother's language.

Résumé

En nous basant sur certains postulats psychanalytiques et sur des observations cliniques, il nous semble que les premières expériences entre la mère et l'enfant ont un rôle fondamental dans le développe-

ment des processus de communication. La mère, grâce à la stabilité et aussi à la souplesse de ses processus d'identification, doit être capable de passer d'un niveau non-verbal de communication à un niveau verbal, selon l'âge et les besoins de son enfant. Les mères d'enfants schizophrènes, n'étant jamais parvenues à établir au-dedans d'elles-mêmes un équilibre stable entre les demandes du principe du plaisir et les demandes du principe de réalité, ont été incapables d'adapter leur mode de communication à un niveau approprié aux besoins de leur enfant. Des déficiences dans le développement du langage sont apparues chez l'enfant. Dans les cas où la mère, sous l'influence du principe de réalité, a utilisé trop tôt et d'une manière exagérée des formes verbales de communication, l'enfant n'a développé aucune forme de langage. Dans les cas où la mère, sous l'influence du principe du plaisir, a favorisé et prolongé les échanges au niveau non-verbal, l'enfant a développé un langage bizarre et défiguré. Nous nous proposons de vérifier une telle hypothèse par une étude intensive et méthodique d'autres cas de mères et d'enfants schizophrènes.

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"SYNDROMES HYPERMOTEURS ET TRIFLUOROPÉRAZINE"*

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Dans une recherche actuellement en cours, les effets prolongés de la Trifluoropérazine sur les fonctions de l'Ego sont étudiés. Les recherches se poursuivent à l'Institut Clairséjour, école résidentielle pour garçons caractériels. Ce rapport préliminaire présente quelques données sur un aspect particulier: l'hypermotricité. Ce rapport est un bref résumé, le texte intégral sera publié dans une autre revue médicale.

Matériel. Trente-trois des garçons fréquentant l'école présentement sont les sujets de cette recherche. Leur âge varie de 7 à 12 ans. Ils sont tous pensionnaires. Ces 33 enfants furent groupés, pour fins de recherche, en trois groupes, comparables quant à leur pathologie, de 11 enfants chacun.

Méthode. Tous les patients ont subi des examens psychiatrique, neurologique et psychologique complets au début de la recherche et à tous les deux mois. Trois tests psychologiques furent administrés: le Bender-Gestalt, le Goodenough et le Dessin de l'Arbre. Le comportement des enfants fut enregistré sur une feuille d'observation que nous avons mise au point. Une valeur numérique a été attribuée à ces observations pour pouvoir les reproduire sous forme graphique. Les patients étaient vus régulièrement une fois par semaine par l'un d'entre nous. Un groupe reçut de la Trifluoropérazine, le deuxième groupe un placebo, et le dernier groupe ne recevait aucune médication.

Résultats. (*Figure 1*). *Hypermotricité.* La figure I montrant les courbes des trois groupes parle d'elle-même. Les résultats seront discutés plus loin.

Doses. Ceux dont l'hyperactivité était améliorée par la Trifluoropérazine répondaient à une dose de 0.5mg./par 10 lbs de poids/par jour.

Effets secondaires. Dans le groupe soumis à la Trifluoropérazine, il n'y eut pas d'effets secondaires. L'akinésie légère nous semblait faire partie intégrale de l'action médicamenteuse, et ne nous semble pas devoir être considérée comme un effet secondaire. Dans le groupe recevant un placebo, un spasme de torsion fut observé.

Discussion. La considération qualitative et quantitative des courbes de l'activité motrice des patients étudiés ici nous a permis de grouper celles-ci en trois classes. Deux classes spécifiques et distinctes, que nous considérerons, et une troisième classe mal délimitée, mélange des deux premières. Nous faisons seulement mentionner cette troisième classe.

I—Une activité motrice, (*Figure 2*), capable de variations, se traduisant par des oscillations dans les courbes, traduit toujours chez nos patients un terrain neurologique normal. De plus leur pathologie motrice était l'expression de troubles émotionnels, constituant une réaction affectivomotrice d'origine psychogénique. L'hypermotricité, quand elle se produit chez ces patients semble être contrôlée assez bien par des doses minimes de Trifluoropérazine. Notons que les Placebo et la Thérapie de Milieu ont un effet semblable, mais moins marqué. Les tests Bender-Gestalt, Goodenough et Dessin de l'Arbre, administrés à ces patients, montraient une réponse affective diminuée aux stimuli extérieurs, après thérapie à la Trifluoropérazine. L'impulsivité semblait être diminuée, et ils semblaient être plus capables d'introversion que d'extroversion, contrairement au début.

Les oscillations de cette courbe peuvent facilement rejoindre les deux extrémités de l'échelle, c.-à-d. que, cliniquement, le

*Projet de recherche rendu possible par un octroi de la maison SMITH KLINE & FRENCH, qui a aussi gracieusement fourni les comprimés de Placebo et de Stelazine.

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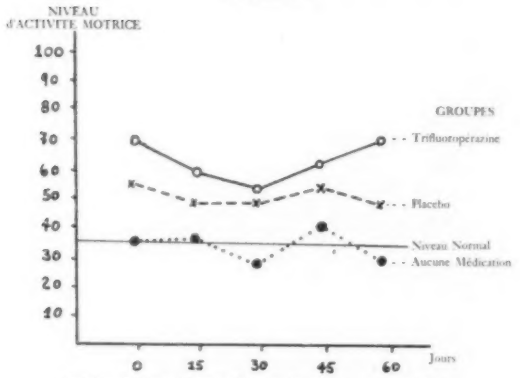
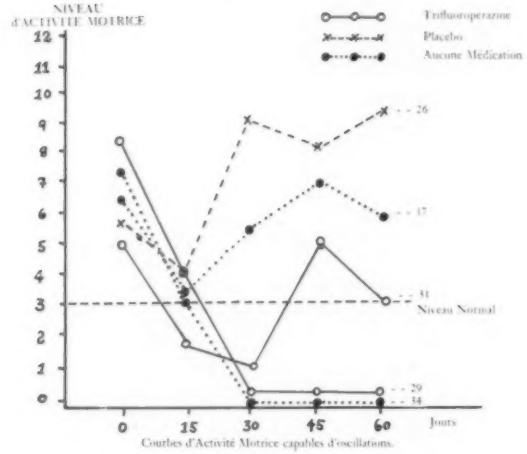
FIGURE 1



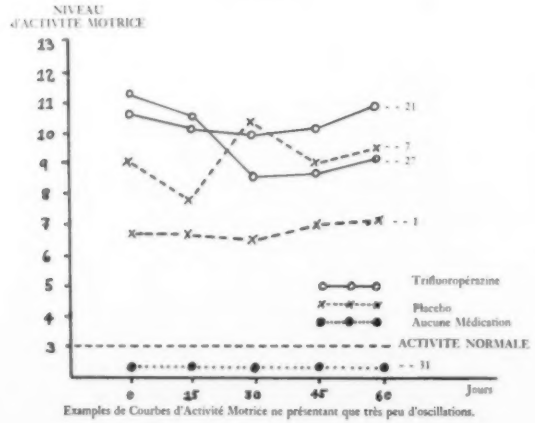
Variations de l'Activité Motrice Collective dans les trois groupes d'enfants.

FIGURE 2



Courbes d'Activité Motrice capables d'oscillations.

FIGURE 3



Examples de Courbes d'Activité Motrice ne présentant que très peu d'oscillations.

patient peut se montrer hypoactif une journée pour devenir hyperactif quelques jours plus tard. Les patients de ce groupe soumis à la Trifluoropérazine subissent une diminution des oscillations de leurs courbes: i.e., répondent moins aux stimuli intérieurs et extérieurs. Cette réactivité motrice diminuée a été confirmée par le Bender-Gestalt et le Dessin de l'Arbre. Ces changements se manifestent aussi par une akinésie légère, toujours accompagnée par une diminution de l'écriture chez les sujets de ce groupe. L'hyperactivité se produisant chez ce genre de patients nous semble une indication précise pour la Trifluoropérazine.

II—Courbe obéissant à un pattern bien défini, (*Figure 3*) ses caractéristiques sont une monotonie de la courbe et une absence d'oscillations normales de l'activité motrice. L'activité motrice est fixée dans une hypermotricité constante et peu réductible par la Trifluoropérazine, la Thérapie de Milieu ou les Placebos. L'association de cette courbe à des facteurs neurologiques et psychiatriques, nous semble particulièrement importante. Neurologiquement, ces enfants présentent un Syndrome Extra-Pyramidal, souvent fruste et défini par une hypertonicité musculaire, un phénomène de roue dentée, etc. Cette pathologie affectivomotrice peut être expliquée possiblement par une régression ou une fixation à un stade archaïque du développement moteur. Au point de vue psychiatrique, les patients présentent des signes évidents de carence affective, de dépression anaclitique, tels que monotonie d'affect, manque d'anxiété libre et froideur de contact.

Ce second type de patients représente l'enfant moteur par excellence. Ce groupe cependant diffère du "Syndrome de Comportement Hyperkinétique Organique" décrit par Zarling. Ces patients sont monotones dans leur activité aussi bien que dans leur affect, ne peuvent subir de frustrations et voient leur impulsivité se traduire immédiatement en action. Il n'existe pas d'anxiété libre, car la moindre anxiété naissante est liée au système moteur et se traduit immédiatement par de l'hypermotricité. Cette triple association: dépression anaclitique, hypermotricité stable, et syndrome extra-pyramidal, fournit une approche tridimensionnelle intéressante pour l'étude de ces cas. La personnalité vraiment motrice de ces enfants, selon les concepts de Mittelmann, nous semble être une fixation ou une régression au stade moteur de développement. Nous avons l'intention d'orienter nos recherches ultérieures en attaquant les trois points de cette association. Il serait intéressant de vérifier si les thymoleptiques, en diminuant la dépression, pourraient diminuer l'hyperactivité et amoindir le syndrome extra-pyramidal. Nous pensons aussi à l'approche psychologique de ces cas, un cas de dépression anaclitique et autisme, accompagné d'une hypermotricité stable et d'un syndrome extra-pyramidal, est en psychothérapie analytique avec un d'entre nous (LG) depuis plus d'un an, et avec l'amélioration de son état autistique et dépressif, il se produit une évolution de maturation et une diminuation de l'hyperactivité et aussi une disparition progressive des signes extra-pyramidaux.

L'approche neurologique de ces cas pourrait peut-être aussi nous fournir une thérapie prometteuse. Quelques cas non-rapportés (LG & RL) après avoir été soumis à la Trifluoropérazine sans succès, ont été traités avec une phénothiazine non-pipérazinée, et avec le relâchement musculaire consécutif, l'hypermotricité est disparue au moins partiellement. Ces patients n'ont pas été suivis assez longtemps pour que l'action du médicament sur la dépression ait pu être appréciée.

Conclusions et résumé. Dans une étude avec groupes contrôlés, l'action de la Trifluoropérazine sur l'hyperactivité fut étudiée. Il n'existe pas de différence notable entre les trois groupes quant à la quantité d'hyperactivité collective proportionelle durant les deux mois d'observation. Il existe même une tendance vers l'hyperactivité plus marquée dans le groupe à la Trifluoropérazine vers la fin de l'observation. Cette apparente ineffi-

cacité peut cependant être expliquée par l'action contraire du médicament dans les deux sous-groupes d'enfants hypermoteurs. Dans le sous-groupe où l'hyperactivité est une réaction affectivomotrice à un conflit psychique, le médicament provoque une baisse marquée de l'hyperactivité. La thérapie de milieu et les placebos exercent une action semblable, mais moins marquée. Dans le sous-groupe dont l'hyperactivité est fixée d'une façon monotone et presque invariable, le médicament a plutôt tendance à exacerber la pathologie motrice. C'est dans ce groupe que nous retrouvons aussi un syndrome extra-pyramidal, des signes de dépression anaclitique et d'hospitalisme. Une monotonie d'activité a été décrite, qui correspond et est associée à la monotonie d'affect retrouvée chez ces patients.

Summary

In a long term research project we are investigating the effects of Trifluoroperazine on Ego functions and Ego structuration in children with character disorders. Enough data has been collected on a specific aspect: motor activity, to be reported here. Thirty-three children, all boarding in a residential school were chosen. All of them were investigated by a psychiatrist, a neurologist and a psychologist at the start of the experiment. The psychological tests used were the Bender-Gestalt, Goodenough and Draw-A-Tree Test. These examinations were repeated after two months.

The children were then divided in three comparable groups, as regard the psychiatric, neurological and psychological pathology. Only some aspects of behaviour were not equally divided among the three groups. For instance, hypermotility was equally distributed in two groups, but nearly absent in the third group, which is then used as a control for the level of collective motor activity in the institution.

One group was put on Trifluoroperazine, the second group on a placebo, (identical to the active tablet) and the third group was without medication. These groups did not correspond to natural groups inside the institution, and only one of us knew the code. Trifluoroperazine and placebo were prescribed at a dose of 0.50 mg./per 10 lbs of body weight/per day. The doses were increased when needed after two weeks, at a ration of 0.25 mg./per 10 lbs. The children were seen regularly for 5-10 minutes once a week, and a complete observation form filled every two weeks by the nursing and teaching staff. We have devised a method to obtain a score from these observations and plot them in a graph. *Figure 1* shows our results with Trifluoroperazine. The poor results on the collective activity of group I is explained by its opposite effects on two types of hyperkinetic children. The qualitative and quantitative study of the individual motricity curves allows us to distinguish two main types of hyperactivity.

Type 1 (*Figure 2*): A curve with wide oscillations, the incursions of which travel at any point of the ordinate. These curves are obviously given by children whose motor activity is capable of variations. These children so grouped according to their curves, show a normal neurological examination and no sign of anaclitic depression. They respond well to Trifluoroperazine, with a mild akinesia, handwriting changes and a decrease in their motor activity. Small doses are sufficient. This type of hyperactivity is a good indication for the drug.

Type 2 (*Figure 3*): The characteristic of this curve is relative flatness. Clinically these patients exhibit flatness of affect, depression, and all have an Extra-Pyramidal Syndrome (not associated with medication). This association, flatness of motor activity and flatness of affect with depression seem interesting. We discuss at length the possibilities for research in this group. Trifluoroperazine would seem to be contra-indicated in these children, since it has a tendency to exacerbate their hyperactivity.

CONSIDÉRATIONS SUR L'IDENTITÉ CLINIQUE ET DIAGNOSTIQUE DE LA SCHIZOPHRÉNIE INFANTILE*

JEAN DELÂGE, M.D.[1]

A la suite des travaux de Morel et surtout de Kraepelin qui définirent la démence précoce, Kahlbaum, Bartschinger et principalement Sante de Sanctis (1906) affirmèrent l'existence d'une démence précoce chez l'enfant et publièrent des observations démonstratives. Sante de Sanctis proposa le terme de démence précocissime ou prépubérale. Kraepelin en reconnut la réalité et montra que la démence précoce "pouvait s'installer par une série de poussées successives dont la première remonte parfois à l'enfance". Bleuler également écrivit que, "dans le vingtième, au moins, des cas de démence précoce, la maladie a débuté dans l'enfance et notamment au cours des premières années de l'existence".

Heller, vers la même période (1908), décrivit aussi la démence infantile qui porte son nom. Il semble toutefois que Heller confondit démence précoce de l'enfant et séquelles graves d'encéphalopathie et d'encéphalite; plusieurs "démences" de Heller, pour lesquelles il y a eu autopsie se révélèrent des maladies dégénératives progressives des cellules lipoïdiques nerveuses (Tay-Sachs ou Spielmeyer-Vogt).

Cette difficulté à faire le diagnostic différentiel entre certaines séquelles psychiques d'encéphalopathie, d'encéphalite et la démence précoce chez l'enfant très jeune persiste encore. En effet, la schizophrénie chez l'enfant très jeune empêche le développement normal de certaines fonctions, comme le langage, et donne parfois à ces enfants l'apparence de débiles mentaux profonds. Ce problème est difficile au point de vue diagnostic et il a même suscité la création de syndrômes particuliers qu'on a voulu détacher soit de la schizophrénie, soit de l'arriération mentale simple; ce sont: "l'hébéphrénie greffée", de Kraepelin, qui désigne un processus évolutif survenant chez des enfants déjà atteints antérieurement d'oligophrénie; Kraepelin estimait que cet état primitif d'arriération mentale n'est lui-même que le résultat d'une poussée antérieure de démence précoce; la notion de "débilité évolutive" de Targowla et Daussy, puis de Heuyer, Lebovici (1954), Michaux.

Ces différentes théories et subdivisions indiquent la difficulté, qui existe souvent, de trancher nettement la question.

Dès les débuts, toutes ces notions de démence précocissime, de démence de Heller, etc., impliquaient une origine héréditaire et organique. L'école allemande et Lutz en particulier ont publié beaucoup sur cette question.

Une étape capitale a été franchie dans la compréhension de la schizophrénie quand Bleuler a remanié de fond en comble la notion de démence précoce (1911), a décrit "les schizophrénies" et "a insisté sur le fait que la démence précoce, qui est un état démentiel avec affaiblissement mental, ne peut pas correspondre à la totalité des cas et qu'il y a un cadre beaucoup plus large qui est celui, non pas d'une démence envisagée au sens d'affaiblissement, mais d'une "psychose", c'est-à-dire d'une maladie mentale pas forcément accompagnée d'affaiblissement et caractérisée par une psychopathologie très particulière décrite sous le nom de schizophrénie" (Lebovici). Les démences infantiles furent alors démembrées, comme le furent les démences de l'adulte et la notion de "schizophrénie infantile" remplaça la notion de démence infantile. Le cadre descriptif de la schizophrénie fut par la suite très élargi, surtout aux Etats-Unis, avec le résultat pratique que même actuellement il est difficile pour les

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chercheurs et les cliniciens de s'entendre sur la terminologie, et cela, surtout en ce qui concerne la schizophrénie de l'enfant. Dans certains milieux, le moindre accroc, la moindre variation un peu atypique dans le développement de l'enfant sont qualifiés de schizophrénie ou de réaction schizophrénique. Il en résulte une confusion regrettable dans l'appréciation des résultats thérapeutiques, en particulier, mais aussi dans l'étude de l'étiologie et de la psychopathologie de cette maladie.

Certaines réactions affectives un peu bizarres sont rattachées de cette façon à la schizophrénie, et comme elles disparaissent au cours de l'évolution psychologique de l'enfant, soit spontanément, soit sous l'influence d'un traitement, des guérisons totales de schizophrénie infantile sont rapportées et publiées. Nous croyons, comme d'autres psychiatres, que cette "dilution", cette extension injustifiée de la notion de schizophrénie infantile nuit beaucoup à l'évaluation exacte des mécanismes psycho-dynamiques de cette maladie et des thérapeutiques qui lui sont appliquées. Il nous faut revenir à des cadres beaucoup plus stricts sous peine de nous égarer dans des descriptions floues et inconsistantes qui enlèveraient toute valeur à cette entité nosologique.

Kanner a créé, en 1949, le terme "d'autisme infantile". Nous croyons qu'il est en partie responsable de cette extension exagérée de la notion de schizophrénie chez l'enfant et "on comprend, dès lors, que l'extension peut être abusive de ce concept d'autisme infantile et qu'il soit parfois sujet à caution" (Ey). Cet autisme sur lequel nous reviendrons, caractérise souvent la schizophrénie de l'enfant, mais nous ne croyons pas qu'il puisse faire l'objet d'une entité séparée. Pour Kanner, il réduirait la schizophrénie à une réaction affective de l'enfant vis-à-vis des attitudes froides ou rejetantes des parents (surtout de la mère) et il nous semble que cette notion étiologique est maintenant dépassée et controuvée. Sa description de l'enfant autistique, qui perd contact avec le monde extérieur et surtout avec les personnes, se révèle souvent exacte, mais nous mettons fortement en doute la cause invoquée, c'est-à-dire les parents "froids", obsédés, sophistiqués, incapables d'établir une relation chaleureuse avec l'enfant. En 1955, Kanner a publié une nouvelle évaluation de sa théorie, beaucoup moins catégorique, et dans laquelle il affirme que même si la froideur et la rigidité d'un ou des deux parents joue un rôle dans la génèse de l'autisme, c'est insuffisant pour faire apparaître le syndrome. Ces enfants sont différents "depuis le début de leur vie extra-utérine et certains parents ne font que réagir à un enfant lui-même "privé de réaction affective" ("unresponsive"). La théorie de Bender est diamétralement opposée à celle de Kanner, quoiqu'elle admette l'influence, secondaire toutefois, des facteurs psychologiques dans l'étiologie. Pour Bender, la schizophrénie infantile est essentiellement une maladie biologique, d'origine organique; il s'agirait d'un trouble du développement, d'origine embryonnaire, qui perturbe le développement physique, le contrôle de l'homéostase, le développement neuromusculaire et l'organisation des systèmes de perception.

Le milieu ambiant ne pourrait à lui seul provoquer une schizophrénie chez l'enfant. Il doit exister une prédisposition génétique pour que survienne la maladie, même si les conditions de vie familiale peuvent influer sur la gravité, la direction, le moment d'apparition et la forme de la maladie. Bender croit que la schizophrénie est provoquée par un retard de maturation, retard qui est génétiquement déterminé mais dont l'apparition peut être favorisée par des crises physiologiques.

Nous trouvons donc deux grandes tendances étiologiques dans l'étude de la schizophrénie infantile: a) une tendance bio-physiologique qui fait de la maladie une entité distincte, génétique, autonome dans son évolution et bien caractérisée, malgré la diversité protéiforme de ses différents aspects cliniques; b) une tendance plus "psychologique" qui fait de

la schizophrénie infantile une réaction de l'enfant à l'environnement et surtout à la mère froide et hostile dont l'enfant sentirait le rejet, rejet qui déclencherait une anxiété très grande, source de tous les troubles futurs et dont l'enfant se protégerait en "rentrant en lui-même".

Entre ces deux conceptions extrêmes de la maladie, une multitude d'hypothèses étiologiques tentent de concilier les deux conceptions principales et se rapprochent de l'un ou l'autre des deux pôles, biologique et psychologique.

De plus en plus, toutefois, on semble accepter le rôle marquant de la prédisposition, de la structure organique de base et il est rare qu'une théorie étiologique de schizophrénie infantile n'en fasse au moins mention.

Pour Beata Rank, les premières relations affectives mère-enfant sont seules en cause, de même que pour Bettelheim, pour qui seule l'étude psychologique de l'enfant suffit. Ce point de vue est aussi soutenu par Fromm-Reichmann et Szurek, l'attitude de la mère étant pour eux le principal facteur de la genèse de la schizophrénie infantile. Kanner et Despert insistent sur l'importance primordiale de la personalité et des attitudes des parents et sur la qualité affective de la relation parents-enfant. Nous avons vu plus haut que l'attitude de Kanner à ce sujet a beaucoup varié dans le sens constitutionnel et biologique; pour lui, une distinction rigide entre organique et fonctionnel ne peut plus être maintenue. Les psychoses expérimentales démontrent que les changements biochimiques s'accompagnent d'altérations dans les processus de la pensée. Le fait de trouver des anomalies biochimiques ou psychologiques n'est que le point de départ de la recherche étiologique. L'autisme infantile précoce est "un état psychobiologique total". Il faut tenter de comprendre le dysfonctionnement à chaque degré d'intégration: biologique, psychologique et social.

Tous les auteurs ne sont pas d'accord sur l'influence prépondérante de l'attitude maternelle ou parentale. D'après Peck, Rabinovitch, Cramer et Freedman, il n'existe pas de description uniforme de la dynamique familiale des parents d'enfants schizophrènes et il n'existe pas non plus d'attitudes pathologiques des mères, qui puissent être typiques. C'est souvent l'enfant qui ne répond pas à l'affection prodiguée et qui détermine une réaction de retour de la mère ou des parents. (Rabinovitch, Erickson, Escalona, Weil).

Pour les psychanalystes aussi (Freud, Hartmann, Model, Bères, Anna Freud), l'Ego est constitutionnellement déficient; il existe un défaut dans l'appareillage constitutionnel de l'Ego. Ce qui se rapproche de la théorie de ceux qui voient dans cette maladie une forte déterminante génétique et innée.

Bergman et Escalona parlent eux aussi d'un Ego de "mauvaise qualité" native, vulnérable aux traumatismes affectifs. Caplan admet une "dysmaturation" avec stress primaire et stress du milieu.

Eissler, Bak, Modell, Hendrick, Hoffer admettent le trouble inné comme facteur de base, et pour eux, ce trouble existe dans la structure du système perceptuel; Mahler insiste aussi sur l'importance du schéma corporel et de la différenciation de l'image corporelle. Il y aurait, dans la schizophrénie infantile, un arrêt dans le développement de la pensée abstraite et de la maturation affective, arrêt dépendant en grande partie d'un trouble de l'acquisition de la "sensation générale". Ce trouble serait dû à un mauvais fonctionnement du système nerveux dans le domaine du toucher, de la douleur, des sens de la température, des positions, des vibrations, le tout donnant une fausse image du monde extérieur et provoquant un retard dans la formation de l'image corporelle et des autres images que l'enfant doit incorporer. Le tonus musculaire troublé influerait beaucoup sur le sens de gravité et déterminerait des changements dans les relations spatiales et les débuts de la relation aux objets (Bender). D'où, en général, une mauvaise intégration du sens de "l'identité".

Du côté biologique, plusieurs auteurs préconisent la pluralité des causes (Fabian, Holden, Sackler). Dans cet ordre d'idées, l'opinion de Bellak nous semble bien représentative: "doivent être considérés et évalués, les facteurs anatomiques, biochimiques, endocriniens, génétiques, infectieux, physiologiques, psychologiques et sociaux. La cause première peut être psychogène ou somatique. Le dénominateur commun serait une diminution de la force de l'Ego, qui empêche celui-ci de devenir le médiateur adéquat entre les instances de l'Ego et de l'Id et la réalité. Il y aurait régression à des structures plus primitives de comportement, c'est-à-dire au comportement qu'on appelle "schizophrénique".

La théorie de Lauretta Bender nous semble la plus proche de cette conception de la maladie et nous voulons terminer cette vue d'ensemble de la "notion de schizophrénie infantile" par un résumé succinct de sa pensée, élaborée après une expérience de vingt ans dans le monde de l'enfant schizophrène:

La schizophrénie infantile est une entité clinique apparaissant chez l'enfant avant l'âge de dix ou onze ans, qui se caractérise par des troubles à tous les degrés et dans tous les domaines de l'intégration du fonctionnement du système nerveux central, que ce soit végétatif, moteur, perceptuel, intellectuel, affectif ou social. La maladie schizophrénique est considérée comme un trouble de la personnalité totale, ayant un substratum essentiel biologique, probablement une sorte "d'encéphalopathie", à laquelle l'enfant réagit comme à une lésion organique, habituellement d'une manière névrotique, déterminée par l'ensemble de sa personnalité et son degré de maturation. Le processus schizophrénique est conçu comme une menace à l'organisation de la personnalité qui bloque les structures normales de développement de l'unité biologique et de la personnalité sociale et qui provoque une réaction caractéristique névrotique ou psychotique due à l'anxiété mobilisée, créée par les déficiences végétatives, motrices, perceptuelles et psychologiques. L'enfant ne peut percevoir, sentir, atteindre le monde comme un enfant normal et il réagit en conséquence. Il existerait une faille dans la maturation embryonnaire, et cette faille serait déterminée par l'hérédité (ou les mécanismes génétiques déréglés) et activée par des crises physiologiques comme la naissance, la puberté, etc.

* * *

Certains observateurs, comme Mahler, ont tendance à poser le diagnostic de schizophrénie infantile dans tous les syndromes névrotiques plurisymptomatiques de l'enfant, syndromes où dominent l'anxiété diffuse, ses manifestations, et les modes réactionnels de l'enfant. Si nous acceptons "l'autisme infantile" de Kanner comme une forme indiscutable de la schizophrénie chez l'enfant, nous ne pouvons accepter une extension du syndrome qui inclut des formes nettement névrotiques; l'évaluation du résultat thérapeutique est directement proportionnelle au diagnostic posé, et une telle extension de la maladie rend très difficile l'appréciation scientifique des résultats publiés. L'anxiété diffuse est certes un symptôme important, mais il doit s'incorporer à la déviation globale de la structure psychologique de l'enfant dans le développement de son Ego.

Les critères de la schizophrénie de l'adulte ne peuvent être appliqués chez l'enfant. Longtemps, ce diagnostic s'appuyait surtout sur une impression intuitive du clinicien; il ne faut pas négliger cette "sensation" précieuse, mais elle doit s'étayer sur un ensemble de signes cliniques bien définis constituant la "psychose". Les régressions profondes, les fixations qui semblent immuables et les arrêts du développement inexplicables sont des signes importants qu'il importe de retrouver avant de pouvoir porter le diagnostic de schizophrénie. Chez l'adulte, la psychose schizophrénique représente une désorganisation, une désintégration de niveaux d'adaptation déjà acquis, vers

un comportement et une affectivité plus primitifs, plus archaïques. Chez l'enfant dont la personnalité est plus fragmentaire et en voie d'organisation, la psychose est le plus souvent reliée à un arrêt ou à une faillite du développement de l'égo et de ses processus de différenciation. Il en résulte des symptômes bien caractéristiques et bien spécifiques au point de vue du diagnostic.

Spitz insiste sur le fait que l'enfant jeune manifeste sa psychose sous forme de retards, de déformations ou de "paralysies" inhibitrices du développement de l'égo, plutôt que sous la forme d'un trouble grave dans les relations entre les différentes sphères de sa personnalité ou dans l'implication des fonctions supérieures de l'être. Chez le très jeune enfant (surtout avant deux ans), la psychose peut se manifester surtout dans des modifications de la motricité et de l'affectivité qui ne nécessitent pas un Ego complètement organisé, capable de pensée conceptuelle, ni la présence du Surmoi.

Les indices physiologiques et neurologiques recherchés par Bender et Barbara Fish seraient beaucoup plus précieux que les symptômes neurologiques francs qui sont souvent absents; il s'agit d'une étude raffinée du contrôle de la musculature faciale, de la voix, de la motricité générale et de la réponse à certains réflexes posturaux. Ce ne sont donc pas des signes neurologiques au sens habituel du terme, indiquant la présence de lésions ou d'atteintes bien définies du système nerveux. Toutefois, leur valeur diagnostique reste encore difficile à établir, surtout à cause de la minutie qu'ils exigent et la part très importante de l'impression subjective de l'observateur.

Barbara Fish tente en effet de déterminer des critères de "développement atypique" du tout jeune enfant qui pourrait permettre de prévoir le développement d'une schizophrénie infantile. Ces recherches sont à leur tout début, quoique entreprises depuis plusieurs années, mais elles ont une grande importance car elles supposent une étude "longitudinale" de la vie de l'enfant qui confirmera ou infirmera l'hypothèse diagnostique posée à son sujet. Toutefois, cette étude est très délicate car elle suppose une étude neurologique fine, et parfois très subjective, des manifestations neuro-musculaires du nourrisson et du petit enfant.

Cette recherche confirmerait l'hypothèse de Bender suivant laquelle l'enfant schizophrène présente des signes biologiques spécifiques d'une maturation désordonnée: variations de l'homéostase (réaction à la fièvre, aux immunisations, à la maladie; état du système vaso-moteur: pâleur, cyanose, dermographie, etc.; phénomènes allergiques; symptômes respiratoires et gastro-intestinaux; rythme du sommeil; états d'éveil, de somnolence, d'irritabilité, instabilité, etc.), étude du tonus musculaire (état "mollusque" du muscle), développement plus ou moins régulier de l'activité motrice, des tonus posturaux et de la locomotion, de la souplesse corporelle, du degré de sensibilité de la perception et des sens, développement du language, du sens social, de l'anxiété et des mécanisme de défense.

La dissociation affective domine chez l'enfant schizophrène; il ne fait plus de distinction entre l'illusion, le rêve et la réalité, alors que l'enfant normal ou névrosé, même s'il s'y complaît, ne s'y perd pas et connaît les limites de l'irréel. Le schizophrène ne voit plus les relations normales entre le monde extérieur et lui-même; son jeu n'est plus fonctionnel, son activité devient rituelle, rigide et compulsive. Sa principale réaction aux frustrations de la réalité, c'est le retrait en lui-même, sur lui-même (withdrawal). Ses réactions agressives sont violentes et désordonnées.

Les constatations précoces de la mère à propos de son enfant sont très importantes. Elle "sent" une barrière entre elle et son enfant; celui-ci ne répond pas d'une manière affective normale au contact, à la caresse: il ne "vibre" pas. On note souvent dans l'histoire clinique de ces cas des signes de perturbations psychosomatiques: périodes de diarrhée, de

vomissements, de coliques sans causes précises, des périodes de pleurs longues et fréquentes, des troubles du sommeil, une "facilité" pour les infections respiratoires, une grande difficulté à changer d'habitudes alimentaires, troubles non spécifiques qui accompagnent cette irrégularité du développement moteur notée plus haut. Plus tard, s'ajoutent d'étranges variations de l'humeur, des phobies non motivées, une excessive dépendance aux parents ou aux substituts parentaux, dépendance parfois physique ("clinging"), mais sans réponse émotive apparente à l'affection prodiguée, et enfin des troubles du langage.

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La différenciation entre les divers syndromes cliniques compris dans le groupe des schizophrénies infantiles dépend beaucoup de la conception théorique des observateurs. Bender conçoit la schizophrénie comme une maladie de l'organisme tout entier et inclut, comme sous-groupes, les principaux syndromes. Sa conception, très large, que nous avons discutée ailleurs, comprend tous les syndromes décrits par d'autres auteurs comme des entités séparées.

Bender assimile l'autisme infantile précoce de Kanner à ce qu'elle appelle le "pseudo-déficient"; les enfants décrits par Mahler comme souffrant de "psychose symbiotique" semblent correspondre au type "pseudo-névrotique" de Bender; enfin, un troisième sous-groupe est décrit comme "pseudo-psychopathique". La maladie apparaîtrait entre zéro et deux ans dans le premier groupe, entre trois et cinq ans dans le deuxième, et vers dix ans dans le troisième.

Plusieurs des groupes décrits par les auteurs découlent de conceptions psychanalytiques et de l'étude psychologique des manifestations et des déviations de la structure de l'Ego vis-à-vis de la mère, du milieu ambiant et du monde extérieur. L'autisme précoce de Kanner est une manifestation schizoprénique qui peut se rattacher au développement ultérieur de la maladie; ses deux principales caractéristiques sont une tendance extrême à l'isolement et l'insistance obsessive à la répétition d'actes, de gestes. Son apparition serait un phénomène de la première année de la vie, alors que déjà on perçoit un manque d'intérêt total pour les êtres humains. Il est considéré par certains auteurs comme un syndrome schizophrénique et par d'autres comme un entité nosologique différente.

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La présence de symptômes obsessifs-compulsifs dans le syndrome schizophrénique rend parfois le diagnostic difficile entre la névrose obsessive et la schizophrénie; il existe beaucoup de points de ressemblance entre les deux maladies, surtout chez l'enfant. Dans le fonctionnement global de la personnalité, de l'Ego, les névrosés obsessifs conservent assez de "reality testing" (appréciation de la réalité) pour reconnaître la pensée obsessive et l'acte impulsif comme étrangers à leur personnalité; chez le schizophrène, dont l'Ego est désorganisé, les pensées et les actes morbides symptomatiques ne sont plus évalués correctement par le malade, ne sont plus générateurs d'anxiété (du moins à un certain stage de la maladie). L'anxiété du névrosé serait issue du conflit oedipien non résolu tandis que celle, précoce, du schizophrène serait due à une carence affective grave de la période prégénitale (Despert).

L'acte impulsif serait un moyen de défense contre la culpabilité ressentie par le névrosé, et sa préoccupation au sujet de la mort servirait d'auto-punition, tandis que la même préoccupation chez le schizophrène prendrait la forme d'une identification totale à la personne décédée ou à "celle qui cause la mort". L'important, quel que soit le mécanisme en cause, c'est que le névrosé garde intact son contact avec la réalité, les personnes et les choses, ce qui n'est pas le cas pour l'enfant schizophrène. De plus, l'évolution fréquente de la schizophrénie de l'enfant vers une désintégration de la personnalité

(hallucinations, mutisme, comportement stéréotypé et rigide, négativisme obstiné, colères et agitation de type catatonique) n'existe jamais chez le névrosé. Si bizarre que soit la pensée obsessive ou l'acte impulsif, le névrosé les reconnaît comme anormaux et les dissocie de son moi; ils ne font pas "partie de lui"; il réalise "leur qualité parasitaire". Le fonctionnement intellectuel du schizophrène, spécialement en ce qui concerne la pensée abstraite, est sérieusement handicapé, alors que chez le névrosé obsédé la fonction intellectuelle n'est pas troublée dans sa structure; c'est le "parasitisme" de l'obsession qui distrait l'enfant de son milieu ambiant et l'empêche d'utiliser pleinement son potentiel intellectuel (Despert).

La rareté des états dépressifs graves chez l'enfant avant la puberté, du moins dans notre milieu, le caractère cyclothymique dominant, la conservation de l'affectivité (exaltée dans le sens de la dépression ou de l'excitation), et surtout l'absence de toutes les bizarreries du comportement rendent ce diagnostic différentiel relativement aisé.

La "dépression anaclitique" de Spitz, connue aussi sous le nom d'hospitalisme, est assez bien décrite comme réactionnelle à la séparation d'avec la mère (ou son substitut) pour qu'il soit possible de la différencier d'un début de schizophrénie. Certains signes peuvent faire penser à un syndrome schizophrénique aigu: une anxiété et une appréhension généralisées avec effondrement affectif, pleurs, absence apparente de contact avec le monde ambiant, repliement sur soi et rejet des attentions de l'entourage, retard du développement psycho-moteur et des réactions aux stimuli, lenteur des mouvements, stupeur et inertie, insomnie et sommeil troublé, perte de l'appétit, du poids. etc. Mais la physionomie "dépressive" de ces enfants est quasi pathognomonique, contrairement à l'absence d'expression du schizophrène ou à la discordance de sa mimique, à ses tics et ses gestes stéréotypés. Et surtout, le syndrome anaclitique apparaît après une évolution et un comportement normaux de l'enfant dans sa famille. Il est spécifiquement déclenché par la disparition subite de la figure maternelle (décès, départ de la mère et surtout hospitalisation de l'enfant). Quand la séparation n'est pas trop longue, la réaction psychologique et physique de l'enfant n'est pas irréversible, et la réunion avec la mère, la réintégration dans le milieu habituel ou une psychothérapie appropriée sont suffisants pour guérir l'enfant.

Pour le schizophrène, la mère, même présente, n'est pas "perçue" affectivement par l'enfant. Il en est tout autrement dans les "névroses d'abandon".

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La schizophrénie infantile est parfois très difficile à différencier de certaines maladies organiques et de l'oligophrénie, surtout quand le syndrome schizophrénique est très précoce et bloque les processus normaux du développement psycho-moteur (particulièrement du langage); ainsi en est-il des maladies suivantes: oligophrénie, surdité et surdimutité, surdité ou agnosie verbale, retards spécifiques dans l'élaboration du langage, mutisme hystérique prolongé, maladie de Heller, encéphalopathies et encéphalites infantiles, maladies dégénératives (maladie de Schilder, etc.), et troubles prépsychopathiques du comportement.

Les facteurs physiologiques, organiques et métaboliques susceptibles d'éclairer l'étiologie de la schizophrénie infantile (comme de la schizophrénie de l'adulte) sont actuellement le sujet de nombreuses recherches. La tendance de ces recherches n'inclut pas seulement les troubles anatomo-physiologiques et chimiques du fonctionnement cérébral, mais une conception plus large des processus biologiques généraux, qui tente d'intégrer l'hérédité et les troubles génétiques, la physiologie normale et pathologique du développement psycho-moteur de l'enfant, le dynamisme évolutif psychologique de la personnalité globale, en tant que partie intégrale de la biologie et de l'expérience humaine.

Le diagnostic différentiel entre la schizophrénie et ce qu'on appelle les "maladies lésionnelles" du cerveau, de même que la co-existence de schizophrénie et de lésions cérébrales, font toujours l'objet de recherches, surtout pour des raisons pronostiques et thérapeutiques. La démence précocissime de Sanctis, caractérisée par des maniérismes, la conservation des attitudes, des stéréotypies, du négativisme, de l'écholalie, la diminution de l'affectivité et conduisant à une détérioration intellectuelle rapide, a perdu de sa vogue comme problème diagnostic différentiel depuis qu'il est devenu évident que ce syndrome renfermait plusieurs maladies complètement autonomes.

La maladie de Heller, dont les symptômes ressemblent à la schizophrénie infantile, s'en différencie par la présence de changements histopathologiques au cortex cérébral. Son début est très aigu et l'apparition de symptômes physiques chez l'enfant aide à l'identification; elle se rapproche beaucoup plus des maladies dégénératives du cerveau. Son évolution est rapide, conduisant à l'idiotie complète en trois ou quatre ans. Il existe souvent des crises convulsives et l'encéphalographie gazeuse révèle des lésions cérébrales majeures. Elle est aussi très rare et certains auteurs en font les séquelles d'une encéphalite à virus ou la manifestation atypique de maladies hérédo-dégénératives ou d'encéphalites démyélinisantes subaiguës du type Van Bogaert. Quand la biopsie du cortex cérébral peut être faite, on trouve de la "rétraction" cellulaire, de la vacuolisation et des "agglomérations" de la substance de Nissl.

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L'ancienne conception suivant laquelle l'enfant schizophrène devait avoir eu une période normale de développement avant l'apparition de la maladie ne peut plus être retenue comme critère de diagnostic différentiel. Bender rattache la schizophrénie infantile au groupe des troubles du comportement d'origine biologique ou "organique", insistant sur la présence de la maladie dès la naissance et même dès la période prénatale, puisqu'elle serait une maladie de l'embryogénèse. Les problèmes psychologiques de l'enfant schizophrène et de l'encéphalopathe seraient à peu près les mêmes quant à la structuration du comportement dans les domaines moteur, perceptuel et affectivo-social, avec une tendance au retard et à la régression de la maturation globale; l'intégration des fonctions intellectuelles se fait mal, l'anxiété diffuse s'installe. Cette anxiété de base, chez le schizophrène et chez l'encéphalopathe, serait due à la structuration insuffisante des fonctions, à la difficulté de percevoir et de communiquer avec le monde réel et à la frustration ressentie plus ou moins consciemment. La perception du schéma corporel est faussée, déficiente.

Les enfants présentant des séquelles encéphalitiques souffrent aussi de troubles de perception dans l'orientation spatiale et de dysfonctionnement mnésique (mémoire visuelle ou auditive surtout). Chez les encéphalitiques, les fonctions perceptuo-motrices ont été lésées; chez le schizophrène, il existe un défaut de développement dans la capacité d'intégration de ces fonctions. L'hyperactivité motrice de ces enfants serait une tentative de prise de contact avec le monde extérieur afin de "l'expérimenter" et de "réintégrer" ces expériences perceptuelles dans un effort continuel d'orientation, au milieu d'un monde qui leur apparaît hostile.

Le diagnostic différentiel est parfois très difficile entre la schizophrénie infantile et l'encéphalopathie, infectieuse ou autre. Bradley insiste sur l'importance de certains détails des tests psycho-métriques, sur la présence dans l'histoire clinique médicale d'une cause présomptive de lésion cérébrale (encéphalites des maladies banales de l'enfance), sur les signes neurologiques d'atteinte ou d'irritation cérébrale, les tracés électro-encéphalographiques, etc. Il faut insister sur l'observation des réflexes de posture, de la motricité et de la façon d'entrer "en re-

lation" (to relate) avec le monde ambiant et les personnes. Un électroencéphalogramme anormal, sans signes organiques, neurologiques dans les tests cliniques et psychologiques, ne peut aider beaucoup au diagnostic différentiel. D'autre part, certains enfants atteints de lésions cérébrales peuvent avoir des tracés normaux (comme certains épileptiques). L'encéphalopathe, malgré son arriération, fait habituellement un effort pour réussir les tâches proposées dans les différents tests; le schizophrène s'en désintéresse ou s'en détourne.

Les épisodes confusionnels ou délirants doivent aussi être différenciés de la schizophrénie, de même que l'encéphalite aiguë ou sub-aiguë; dans ces états morbides, l'instabilité psycho-motrice, l'obnubilation de la conscience, les crises convulsives, etc. dominent le tableau, en plus des signes physiques habituels de ces affections. Se basant sur les changements importants du comportement qui résultent fréquemment d'une atteinte encéphalitique prouvée, même si elle est de courte durée, beaucoup d'auteurs insistent de plus en plus sur la relation importante de la structure neurale avec la fonction psychologique dans le comportement humain et sur la nécessité de rechercher les processus organiques, physiques, métaboliques et physico-chimiques qui pourraient être déficitaires et conditionner, partiellement du moins, l'apparition du syndrome schizophrénique.

Les ressemblances entre la schizophrénie infantile et l'oligophrénie sont étudiées depuis longtemps; on a confondu et on confond encore les deux maladies. Le comportement de l'arriéré et celui de l'enfant autistique ont plusieurs points communs. Ces deux types d'enfant n'ont jamais développé la capacité d'établir un contact, une relation significative avec le milieu. Des causes psychologiques et organiques interfèrent dans le fonctionnement mental, et le dénominateur commun de toutes les maladies résultant en une "déficience mentale" serait une anormalité présente à la naissance et due à une cause héréditaire ou dysgénétique (Benda). Loin d'être un individu "normal", sauf en ce qui regarde le développement et la capacité intellectuels, l'arriéré mental est souvent une personne "psychotique", dont le comportement imprévisible ressemble souvent à celui du schizophrène. Quels sont les facteurs qui produisent l'arriération intellectuelle, quels sont ceux qui provoquent la désorganisation globale du schizophrène, seule la recherche intégrée de toutes les disciplines médicales, biologiques, psychologiques et sociales pourra permettre de trouver les facteurs qui nuisent à la maturation de l'intelligence et ceux qui bloquent l'intégration harmonieuse de toute la personnalité.

Il est habituellement possible de différencier les deux maladies; chez le schizophrène, il existe ou il peut exister de bonnes potentialités intellectuelles: les tests et la clinique en font foi. La tendance à l'isolement, les maniérismes et l'activité rituelle du schizophrène sont différents des gestes stéréotypés de l'arriéré pour le clinicien habitué; la "bizarrerie" et l'étrangeté de la présentation du schizophrène ne se rencontrent pas dans la présentation habituelle du déficient.

C'est dans ces cas qu'il est difficile d'évaluer l'intelligence primitive de l'enfant, celle-ci n'ayant pu même s'organiser suffisamment pour être testable avant que la dissociation schizophrénique ne vienne la sidérer. Tout ce qui est décrit comme mécanisme négatif du processus schizophrénique dans une intelligence intégrée doit aussi être pris en considération dans une intelligence qui commence à peine à se structurer ou avant même toute structuration: défaut de mémoire et d'attention, de jugement, de raisonnement, d'initiative, d'adaptation à une situation nouvelle; le défaut de la synthèse psychique entraîne l'improductivité. Il n'est donc pas surprenant qu'une schizophrénie très précoce ou dont les manifestations apparaissent dans les premiers mois de la vie (autisme) nous donne un tableau difficile à distinguer de l'oligophrénie.

Après une étude multidimensionnelle et psychobiologique, Greenblatt et Solomon divisent les schizophrènes en deux catégories:

a) les uns ayant conservé leurs facultés d'abstraction et d'intégration et exprimant leur tension intérieure par un certain mode de relations sociales et d'expression verbale;
b) les autres, désintégrés, (ou non intégrés, dirions-nous après ce qui précède, quand la maladie frappe jeune) avec un pouvoir d'abstraction diminué pour ainsi dire, sans tension intérieure, et qui ont perdu jusqu'à la capacité d'exprimer leur insatisfaction verbalement ou dans leur comportement social.

Nous croyons que les enfants touchés très jeunes par le processus schizophrénique (ou frappés plus durement) appartiennent au second groupe.

Les tests d'intelligence et de personnalité sont précieux pour le diagnostic différentiel; certains tests et sous-tests sont parfaitement réussis par le schizophrène qui seraient impossibles à réaliser pour le déficient.

Nous ne voulons pas entrer dans la discussion du détail dans le rendement aux tests d'intelligence, mais seulement en signaler les principales caractéristiques. Nous avons déjà mentionné le fait que ce qui caractérise surtout le rendement général du schizophrène aux tests de rendement intellectuel, c'est le fait de réussir adéquatement certaines épreuves ou "sous-tests" et d'échouer lamentablement à d'autres épreuves d'un même niveau: c'est la dispersion ou "scatter", dans un même test ou inter-tests.

On a ainsi mis en évidence (Rabin) la supériorité des schizophrènes dans les tests d'information et de compréhension et leur infériorité à l'assemblage d'objets et surtout au code chiffres-symboles. Wechsler lui-même a trouvé un type de dispersion du même genre; pour lui, une infériorité primaire aux similitudes, contrastant avec des scores élevés au vocabulaire et à l'information, aurait une valeur pathognomonique. On a aussi signalé leur faiblesse en raisonnement arithmétique. Il existe donc un coefficient considérable de variations et de fluctuations dans les divers sous-tests et même lors des retests. La dispersion caractéristique des scores (scatter) serait significative de la détérioration des schizophrènes, ou si l'on préfère du trouble de fonctionnement ("functional impairment"). D'après Rapaport, c'est le déficit de certaines opérations verbales, la dispersion des sous-tests verbaux et la faiblesse du rendement aux épreuves "performance" qui souligne le rendement schizophrénique.

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Que le diagnostic différentiel se soit affiné et qu'il ait permis d'écarter des cas qui ne sont pas réellement des schizophrénies infantiles ne change pas le pronostic des vrais cas de schizophrénie.

Les critères de diagnostic sont très larges dans certains milieux, et surtout aux Etats-Unis, et souvent le diagnostic de schizophrénie, par la lecture de l'observation, peut être sérieusement mis en doute. Les auteurs qui favorisent cette façon de procéder affirment qu'il est toujours dangereux de poser un diagnostic psychiatrique précis chez l'enfant et que puisqu'il y a, avec leurs techniques, amélioration ou guérison, le diagnostic exact importe peu. Cette opinion peut peut-être se soutenir dans la pratique quotidienne (quoique nous ne l'admettions pas!), mais elle nous semble néfaste au point de vue de la recherche médicale. A notre avis, la notion de "schizophrénie infantile" doit être resserrée le plus possible et il faut chercher à en exclure tous les syndromes qui lui sont étrangers. Dans l'autre perspective, la médecine, et la médecine mentale en particulier, ne deviendrait plus qu'un amas incongru de symptômes qu'une soi-disant forme de psychothérapie dynamique serait seule à pouvoir expliciter, élucider et guérir! Plusieurs médecins ont protesté récemment contre cette extension injustifiée du syndrome schizophrénique; cette extension explique la fréquence extraordinaire de ce dia-

gnostic dans certains centres et par certains psychiatres et psychologues, alors que dans notre milieu (comme dans plusieurs autres), où les critères diagnostiques sont plus précis et plus stricts, sous l'influence, nous croyons, de la psychiatrie européenne, nous portons plutôt rarement le diagnostic de schizophrénie infantile; et pourtant, nos hôpitaux et nos cliniques pour adultes ont proportionnellement le même nombre de schizophrénies d'adulte que dans les autres centres psychiatriques. Peut-être le diagnostic de schizophrénie infantile est-il trop négligé ou ignoré, mais ce facteur seul nous semble insuffisant pour expliquer la relative rareté de ce diagnostic chez nous.

Il est difficile d'évaluer l'effet d'une thérapeutique de quelque nature qu'elle soit, dans l'évolution d'une schizophrénie infantile, car cette évolution elle-même est variable et certains enfants réagissent, pour un certain temps du moins, à tout ce qui est tenté pour eux, hospitalisation, éloignement du milieu familial, psychothérapie, thérapeutique biologique, etc. Evaluer adéquatement l'influence de la maturation normale de l'enfant est une difficulté de plus.

Certaines équipes, soutenant des théories psychologiques divergentes, travaillent dans l'isolement, affichant souvent un mépris souverain des disciplines psychiatriques et cette attitude retarde la compréhension et la solution du problème schizophrénique. Les équipes de tendances psychologiques négligent trop souvent les facteurs physiologiques et biologiques qui pourtant sous-tendent indiscutablement le fonctionnement cérébral. Les équipes de tendances biologiques, d'autre part, ignorent trop souvent ce que les dernières vingt-cinq années de recherches psycho-dynamiques ont apporté d'enrichissement dans la compréhension et le traitement des troubles affectifs et mentaux.

Les différentes thérapeutiques biologiques et psychologiques peuvent rendre l'enfant plus sociable, permettre une meilleure adaptation familiale et scolaire, faire disparaitre certains symptômes, améliorer son contact humain ou retarder la déchéance psychotique (ou même la bloquer), mais nous ne croyons pas que l'on puisse parler de guérison complète. La recherche doit continuer dans tous les domaines et particulièrement dans celui des processus du développement de l'enfant normal; la recherche étiologique doit se poursuivre dans les secteurs suivants: nature profonde et primordiale de la maladie, structure héréditaire, constitutionnelle et organique, fonctions biologiques et physiologiques, dynamique physico-chimique et psychologique, influence du milieu et des relations interpersonnelles.

Une condition essentielle du progrès de cette recherche, c'est l'exactitude et une franche lucidité dans l'appréciation des formules diagnostiques et thérapeutiques, quelle que soit l'orientation idéologique qui les dirige. Le diagnostic différentiel doit être encore précisé afin d'établir des critères de plus en plus exacts et spécifiques, et de restreindre encore, si cela est possible, l'identité clinique de la schizophrénie infantile.

Summary

Since its earliest descriptions, the concept of childhood schizophrenia has changed considerably. Some contemporary clinicians and researchers have made it so broad as to include a wide range of clinical entities which confuse the picture.

The author has attempted, in the light of the most prevalent psychopathological theories, to untangle this confusion, and stress the importance of the psychotic nucleus in childhood schizophrenia. Pseudo-neurotic and borderline cases should be carefully assessed and eliminated, as well as hallucinatory conditions found in many organic syndromes.

A strict differential diagnosis respecting the essential psychotic components of schizophrenia should help delineate childhood schizophrenia as a separate clinical entity and afford means of re-evaluating the literature on this subject in a more critical light.

GROUP PSYCHOANALYTIC THERAPY IN CHILD PSYCHIATRY*

J. B. Boulanger, M.D.[1]

Child psychiatry is facing to-day a paradoxical situation which cannot persist without grave concern for its future. Requirements and standards in the specialty are continuously rendered more exacting, the need for prompt and early psychiatric care is widely recognized and eagerly voiced; yet few patients are treated in such haphazard fashion by incompetent individuals as are neurotic children in an age dedicated to scientific medicine and public welfare.

An implicit attitude too often encountered in the available facilities for disturbed children restricts to adults the diagnosis of a neurosis and the privilege of psychotherapy. Advice, counseling, guidance, reeducation in manifold forms are offered to families afflicted with "problem" children, "maladjusted" or "emotionally immature" adolescents.

Self-styled therapists with various backgrounds but with identical pedagogic aims have invaded a field which was left waste by psychiatry until very recent times; they now occupy positions of authority and their experience commands respect. In this setting, the child psychiatrist is either tolerated in the protective and inocuous rôle of a consultant or relegated to the fastidious functions of an administrator.

The unfortunate and frequent result is that psychiatric cases requiring the greatest proficiency and skill are entrusted to the care of those whose scientific training is the less adequate. This lack of professional direction and responsibility cannot be condoned by the mystique of team-work nor by the necessities of expediency. A similar shortage of qualified workers and the same advantages of interdisciplinary cooperation are found in all sectors of medical and psychiatric practice, indeed in all social or technical types of human endeavour.

It seems odd that the benefits of an etiologic and prophylactic treatment should be denied precisely to those patients whose personality is the most amenable to deep and lasting changes and whose improvement would be the most valuable to the community. Two major objections are profered against the extension of psychoanalysis to child psychiatry.

The theoretical argument is based on a misconception. Play, drawing, games and language are, at different levels of development, preferential modes of communication, both in reality and in fantasy, and of expression, manifest as well as latent. In the analytic situation, the unconscious conflicts, needs and purposes are unravelled by the method of free association through the interpretation of transference, resistances and defences.

Psychoanalytic technique may be adapted to the medium which is best suited to the age of the child and which is most permeated for this period with symbolic representation and therefore with underlying processes accessible to analysis. The only prerequisite is the maintenance of the conditions essential to an analytic type of therapy and these all originate in the neutrality of the therapist.

*Based on papers read before the Société Canadienne d'Etudes et de Recherches Psychiatriques (Montreal, 30th September, 1959), before the First Committee on Child Psychiatry (Ottawa, 4th June, 1959), at the Tenth Annual Meeting of the Canadian Psychiatric Association (Banff, 16th June, 1960) and at the Third World Congress of Psychiatry (Montreal, 7th June, 1961).

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Observations of child behaviour, case histories of psychotics and neurotics, studies in cultural anthropology and genetic psychology have emphasized the influence of socialization on maturation, identification and object relationships during childhood and adolescence. A group situation provides the ideal setting for a psychoanalytic treatment of neurotics of school age. Thus is obviated the main drawback to psychoanalysis, its low output, which remains the practical objection to its generalized application.

The possibility of devoting to the treatment of seven or eight patients the time usually taken by a single case is not a negligible advantage if one considers the scarcity of trained personnel in child psychiatry. Furthermore, an opportunity is offered to teach the techniques of group psychoanalysis to members of the staff—psychiatrists, residents, psychologists, social workers, etc.—who may take part in the treatment according to their capacities and eventually conduct additional groups, provided they undergo a personal analysis and obtain proper supervision.

A specific approach is suggested for each of the main age categories of psychoneurotic patients referred to the out-patient clinic of a child psychiatric unit —group psychoanalysis by drawing and painting for early latency (5-6 yrs to 8 yrs); group analytic psychodrama for late latency (8 yrs to 10 yrs); verbal group psychoanalysis for both preadolescence (11 yrs to 13 yrs) and adolescence (14 yrs to 16 yrs).

Intensive treatment of a child may be of little avail if the psychopathological climate of the home is left unchanged. Mothers of children of latency age should be required to attend weekly sessions of analytically oriented group psychotherapy, which is much more conducive to insight and modifications in attitudes than case-work or individual interviews.

Ideally, both parents should be treated; in fact, it is quite a feat to have groups of fathers meeting regularly after working hours, at fortnightly or even monthly intervals. Most adolescents and many preadolescents are treated successfully without providing intensive therapy for the parents.

The writer is convinced that the same therapist should not treat both child and parent concurrently. This contention is based on ethical and psychodynamic considerations which are borne out by clinical experience. A child is fully entitled to the respect of the confidential character of his communications and will not relate to an adult who has regular contacts with his parents in another way than he would to a parental delegate.

It is to the advantage of both child and parent that each be involved in his treatment for his own sake without constant reference to the other. The therapist enjoys greater freedom of mind and flexibility of action when he is not influenced by external pressures and distorted information nor inhibited by his ambiguous and divided commitments.

Regular conferences of all those engaged in group therapy promote discussion of theoretical and technical problems and comparison of methods and results. Difficulties in the counter-transference are more likely to be solved in private with an experienced supervisor.

Selection of patients is made on the basis of a psychiatric diagnosis of symptomatic psychoneurosis or character neurosis. A battery of psychometric and projective tests is administered before treatment begins. Psychotics, psychopaths, delinquents and morons are excluded. Under the age of 11 years, groups are mixed. Differences in socio-economic classes and cultural backgrounds do not seem to have a marked bearing before adolescence is reached. A high level of homogeneity is to be expected among subjects referred to an out-patient psychiatric department of a hospital for children.

Group psychoanalytic therapy in child psychiatry was introduced in Canada by

the writer.[1] The first session was held in Montreal at the Hôpital Sainte-Justine pour les enfants on the 20th of January, 1958. The original group consisted of five girls, the youngest being 11 years of age and the oldest, 13, presenting a variety of psychiatric disturbances: phobia, obsessional neurosis, tics, hysteria.

Patients are seated in a circle and are asked "to think out loud" and say everything which comes into their minds. Interpretations are aimed chiefly at resistances, defences and transference manifestations as they develop within the group.

A year and a few months later, group analytic psychodrama was initiated. Three boys and two girls, age 9, with hysterical or obsessional symptoms, formed the first latency group to be treated by this technique.

A "director" and at least two "auxiliary egos" are needed, with a representation of both sexes. The children are invited to imagine "a story", which will be played by the therapists and patients, without any stage, properties or props. The plot, its themes and alterations, the reactions of the children are analyzed in the same manner as free associations. This modified psychodrama has only some technical features (e.g., dramatization, rôle reversal, etc.) in common with the method expounded by Moreno.

In the autumn of 1960, psychoanalytic therapy by drawing and painting was begun with two groups of patients, ranging from six to eight years of age. They are supplied with pencils, crayons, gouache, water colours, finger paints; no directions are given, except to draw or paint whatever they like.

Such productions can be considered, at this age, as equivalent to the spontaneous play of younger children or to the manifest content of dreams in adults; they are explored in a similar manner.

Groups are open, number from five to ten patients, with an average of seven, and meet at weekly intervals during the academic year for a period of time varying from 45 to 75 minutes, according to the age category. In our experience, the school always granted authorization to attend sessions regularly.

Once treatment is started, no individual interviews nor parallel psychotherapy are available to the patient and no personal contact is entertained between the therapist and any member of the patient's environment.

Some among the youngest patients were discharged after one year; a few needed to continue treatment for a third year. A period of two academic years constitutes the average duration for a group.

The therapeutic results observed by the psychiatrists and corroborated by social agencies, families and schools seem to excel, in terms of quality and time, the usual findings of other methods of treatment.

In June 1961, a total of 74 children and 33 parents were under treatment: four groups of 28 adolescent girls and two of 15 adolescent boys, with respectively five and three therapists; three groups of late latency children with six therapists; two groups of 16 early latency children with six therapists; four groups of parents with four therapists.

Three therapists are child psychiatrists and three others, residents in child psychiatry. Also included are three psychologists, three social workers, one occupational therapist and one nursery school teacher. One is a qualified analyst, one is in advanced psychoanalytic training, two others have been in analysis and three are in personal analysis.

For half of the total number of fourteen leading or auxiliary therapists, this was their first venture in psychotherapy; three had worked with groups at other psychiatric centres. Thirty months after the inception of this project, three psychiatrists, two psychiatric residents and one psychiatric social worker were sufficiently competent to conduct groups

[1] Boulanger, J. B.: *Canad. Psychiat. A. J.* 4: 22 22 (Jan.) 1959; *ibid.*, 4: 172 (July) 1959.

on their own, in most cases, as leaders of a therapeutic team.

A weekly total of 30 man-hours provided adequate psychotherapeutic care for 107 neurotics, 74 children and 33 adults, with simultaneous training by apprenticeship for all those who participated in the treatment programme and had none or little previous experience in the technique of both individual and group psychotherapy.

This approach, which answers the growing demands for the early treatment of mental illness and for the rapid increase of qualified therapists in the field of child psychiatry, would make a most felicitous contribution to the welfare of the community.

The writer gratefully acknowledges the collaboration of all the staff members associated with his work and more especially the unfailing and enthusiastic support of Dr. D. Lazure, Director of the Department of Child Psychiatry at the Hôpital Sainte-Justine. The experience gained in group analysis of adults and in individual analytic psychodrama with Dr. F. Pasche at the Laboratoire de psychothérapie of the Paris Faculty of Medicine and with Dr. S. Lebovici at the Hospice de la Salpêtrière Service of Child Psychiatry, inspired the writer to pursue the clinical and therapeutic applications of a methodology which he attempted to elaborate from the confluent sources of genetic psychology, group dynamics and psychoanalysis.

Résumé

L'auteur propose pour le traitement des enfants névrosés d'âge scolaire des techniques psychanalytiques adaptées à leur développement psychologique et reliées à des situations de groupe favorisant leur maturation affective et sociale.

Le dessin est la méthode de choix pour l'exploration thérapeutique des conflits inconscients avec des groupes d'enfants âgés de six à huit ans. A la phase ultérieure de la période de latence correspond le psychodrame analytique de groupe, qui utilise le jeu collectif en vue d'une élaboration interprétative du matériel ludique. Dès la puberté, on peut entreprendre une psychothérapie analytique de groupe sur un plan purement verbal.

Le traitement de l'enfant est incomplet sans celui des parents, qui sont vus en groupes par des thérapeutes distincts. Ce cadre de psychothérapie collective est des plus propices à la formation méthodologique et pratique de psychothérapeutes.

L'auteur introduisit ces méthodes au Canada en 1958, dans le service de psychiatrie infantile à l'hôpital Sainte-Justine de Montréal. Une équipe de quatorze psychothérapeutes principaux et auxiliaires, ne disposant en tout que de trente heures par semaine, traite actuellement 74 enfants et adolescents de 7 à 15 ans et 33 parents, répartis respectivement en onze et quatre groupes.

"THE EARLY STAGES OF PSYCHOANALYSIS OF A 4½ YEAR OLD GIRL"*

TAYLOR STATTEN, M.D.[1]

Criteria of Selection. Six months before starting treatment with this 4½ year old girl the search for such a patient began. A child three or four years old, who was not psychotic, or brain-damaged, who would be able to come to the Montreal Children's Hospital four or five times a week for analysis was being sought. The head paediatrician of the out-patient clinic of the Children's Hospital approached many parents of children with sleep disturbances, feeding problems, phobias and difficulty in separating from the parents. However, when the interpretation of treatment by psychoanalysis came, or even if this were played down and it was revealed that the patient would be required to come to the hospital four or five times a week, then the difficulty arose.

The Patient: "Patsie"—age 4½ years. One of my child psychiatric colleagues found Patsie for me. Her parents were immediately intrigued with the idea of having psychoanalysis for their child. They were concerned about her development because they felt that the two year old brother was gradually catching up with Patsie. They especially felt that her speech was extremely indistinct and that she was unable to form sentences; that she spoke in a jargon which was difficult to understand. They also realized that she was afraid of other children and preferred the company of adults, and that wind storms and lightning were very upsetting for her. The smallest noises seemed to distract her. Each night Patsie would waken and insist upon sleeping with her parents.

The patient was a well-developed little girl with big brown eyes, dark hair, well-padded in baby fat. She was very conscious of her little party dress, smiled in a quizzical way, but tended to keep close to her parents. Patsie was born of a normal pregnancy, labour lasted five or six hours and the birth weight was 8 pounds. She thrived well, being breast-fed for the first year; toilet-training was started early at seven months, and became a big issue. There was much panic on the toilet and she was almost four years of age before she was toilet-trained. Patsie held on to her stools for days and was very constipated; this was relieved by special diets and enemas; she became trained for urination at about 2½ years. She sat up at eight months, walked at fifteen months. Words were slow in development. Since birth she was exposed simultaneously to French, English and Swedish. For about the first year, she was looked after by a French girl, then by an English Jamaican, and more recently by a British English girl. Psychological tests showed her to be functioning at an I.Q. of about 80, but it was felt that she had normal intellectual potential. For the purpose of limiting this presentation, let us add that the family history and background did not appear to contribute directly to the child's disturbance.

The Differential Diagnosis. At the time this case was referred for psychoanalysis the differential diagnosis was (1) retardation; (2) brain dysfunction with auditory hypersensitivity; (3) neurotic inhibition of speech.

First Interview. I met Patsie and her father in the waiting room and asked if she would like to take off her coat and let me hang it up on the hook for her. Her father immediately started to fumble with the buttons. She became quite annoyed. The father started to plead: "it is hot, you need your coat off", etc. It was suggested that perhaps Patsie would like to take it off herself. This she did with a big

*Presented as part of the Child Psychiatric Programme at the Annual Meeting of the Canadian Psychiatric Association, Banff, June 1960.

[1]Associate Professor of Psychiatry, McGill University; Director, Department of Psychiatry, The Montreal Children's Hospital.

appreciative grin and handed the coat to me. Patsie walked down the hall close to her father, looking me over with an expression of great interest and curiosity.

As we neared the doorway the father said he felt Patsie would not go into the room without him. I suggested that he stop at the bench outside the room and that I would show Patsie the room and the toys I had for her. The father ignored my suggestion and came and stood in the doorway and later came in and sat on the end of the couch close to the entrance.

The child version of the analytic rule was then proclaimed. Patsie was told that we would meet in this room each time she came to see me and that in this room she could do anything she wished and say anything she wished, and tell me anything she wished. Anything she told me would be kept as a secret. Daddy and Mummy would not be told anything that went on here and she didn't have to tell anybody about it. Patsie was told she would not be allowed to hurt herself, nor would she be permitted to hurt me. Her drawer was then unlocked and pulled open, explaining it was *her* drawer, that the toys in it were *her* toys and that *nobody* else would play with them and that the drawer would be kept locked until she came the next time. It was explained that I wanted to help her to talk so she could be understood. Patsie then said "where is Mummy " and picked out the paints and the pot of glue. While she was trying to get the lid off the glue I asked the father to move to the hall. There was no protest on her part. She asked me to open the glue pot—"take it out". Patsie dipped the paint brush first into the glue, then into the paint set. She picked up a pad of paper and rubbed the glue-paint product into the paper, got her fingers mixed up in the deal and wiped them off on her pretty clean dress.

A wooden block house was chosen and this was intensely painted with glue. She heard footsteps in the hall and dropped what she was doing and went out to see what was going on. Patsie stamped her way back and continued painting the house. She stopped this, wiped her hands, and cut out pieces of paper. Her attention was changed to the set of small toys and these were dumped into the sink and were washed and dried. She then went to the blackboard and drew on it with chalk and then with pencil, then got the chalk eraser and rubbed out the chalk marks.

Her speech was a jumble and confusion to me and I understood little of it except "where is Mummy?". When she wanted the lid of the glue pot off she said "take it out".

Summary of Material of First 26 Sessions

Defences Against Anxieties Around Separation. The father brought Patsie for the first three weeks. His ambivalence about surrendering his daughter was clearly shown right from the start. However as this was interpreted to him and he finally agreed to leave, Patsie showed no protest. Indeed she gradually expressed more aggression, except for short spells of fearfulness during which she needed to check whether her father was still waiting outside. Eventually during an episode of doll-play she was heard saying very clearly "the hell with Daddy".

Defence Against Anxieties Around Toileting and Curiosities of Sexual Differences. Patsie appeared quite alarmed momentarily when she first discovered a toilet in the therapy room. Her first reaction after the initial alarm was to ignore that she had made the discovery. She pulled out the house and paints and paste, wanting to do everything herself, and started painting the house, then said "time to go home". She went to the window and talked about playing outside, the birds in the park, and not being able to go out without a raincoat. No longer able to control herself Patsie rushed out of the room to tell the maid she was finished and wanted to go home. I told her she was afraid of the idea of going "pee pee" or "ka ka" in the toilet. I assured her she could do this if she wanted to, that was why the toilet was there; on the other hand she didn't have to use it unless she felt she wanted to. On coming back into the therapy room, Patsie ignored the toilet bowl, but played with the flush handle and had me take the lid off the cistern. Following the tenth interview, having played with water and paste with her fingers, she went "pee pee" in the toilet and for the next five or six interviews she usually went "pee pee" or "ka ka" during an interview.

Feeding me many cupfuls of water on many successive interviews finally culminated in an order for me to go "pee pee". She invited me to come into the toilet closet to look at the cistern and watch her put paper in the toilet bowl. On her way out she pushed me aside by putting her hand to the crotch of my pants. Much interest was expressed in the bottoms of male and female plasticine dolls which we constructed. On several occasions, after careful construction, she would rip off the limbs, breasts and penis of the figures and throw them in the sink or toilet. On one occasion, while probing the bottom of a doll with a stick she seemed to become frustrated at not being able to see as much inside the doll as she wished and quickly got up and went to the toilet and went "pee pee" and "ka ka". Then Patsie asked me to come and look at her products and say goodbye to them. The acceptance of her interest in her faeces led to a request to see my genitals and a displayal of her bottom and genitals to me and a request on her part for me to play with them as she did.

Defences and Anxieties Around Fears of Mutilation, Death and Birth. Anxieties around fears of death and mutilation were worked out in many different situations but most obviously in the bedroom scene. Here she would have me go to sleep, turn out the lights and gradually became able to act out some of her dreams about devouring animals with biting teeth and ripping claws. Another theme was being ill in bed and having medicine administered to her by a rough, insensitive doctor, nurse or mother. This feeding activity became very demanding and very aggressive with intent to hurt.

On another occasion she told me I was dead and had me lay down, turned out the lights and sat on my head, then had me come to life and fed me, treating me as if I was a new-born baby.

Defences and Anxieties Over Speech Development. If I talked too much she would often call me "stupid" and tell me to "sut up". Singing and dancing were used in many sessions to convey feelings and moods. She would stand on the little table and dance and sing with wide ranges of affect, often changing from one to another in a split second. Religious songs, hymn-like tunes, nursery rhymes, rock-and-roll and kindergarten tunes were all within her repertoire. The words were seldom pronounced but her face, attitude and gestures were expressive enough to convey the full meaning. Sometimes I would put into words what she was trying to say but more frequent and more acceptable to her were the times when I would give back the same noises she initiated. Sometimes she would have us sing a duet, other times I would have to sing to her.

Discussion

Patsie was seen for over two hundred interviews, with four interviews a week. The progress in her adjustment was very rewarding. She developed a comprehensible speech, a capacity to love, her fears disappeared so that she slept soundly in her own bed and she became much more self-reliant. She was less distractible but there was no real change in her I.Q. by the end of treatment.

Many problems presented themselves during the analysis. One of the important differences between analysis and other types of psychotherapy is the statement and the adherence to the analytic rule (see first interview). It is this and the frequency of contact which makes this difference. Because of the analytic rule the child becomes the unique concern of the therapist. This certainly limits drastically the number and kind of cases suitable for psychoanalysis. For a child psychiatrist whose orientation is in a family-centred approach, the most unsatisfactory and frustrating aspect of analysis is the lack of contact with the parents.

I. The Parents. There was much concern on the part of the parents as to what was going on in treatment: the father even asked to come into analysis himself. In spite of resistances and difficulties, however, the whole family situation seemed to improve as Patsie became more normal, responsive and easier to understand.

II. Working Blind. The parents were asked to report anything unusual that might occur between interviews. This request was seldom granted; moreover, the parents would periodically leave town for Florida or Europe. So it was only slowly, through the jargon and confusion of the child's material, that I would be able to put together what was going on at home. It was often felt that more meaningful interpretations could be made if more information were known about the current situation. In this case, however, it was a tremendous stimulation to the patient to develop a capacity to become more explicit in speech. Also, if the therapist seemed to know all about what was going on outside the interviews, the child would lose the therapeutic impact of feeling the secrecy and uniqueness of the relationship with the therapist. Would the patient not have good evidence for feeling that there was another important relationship with somebody at home and the therapist was telling everything that went on in the interview to somebody else?

III. To Hurt or Not To Be Hurt: "*Won't let her hurt herself*" This child was a fearless climber and she would love to perch on top of the drainboard on a chair and beat out rhythms on the paper towel dispenser. She also wanted to put nose drops in her eyes and washed her face and eyes with strong soap. I tried to allow her to be as adventuresome as possible but would warn her that I had promised not to let her hurt herself and on occasions intervened.

"*Won't let her hurt me*"

This is a little more difficult than might be expected. One feels that a 4½ year old cannot hurt an adult. On one occasion the therapist was not able to rid his mind of a current administrative problem and was sitting with the patient at a small play table. The patient sensed the lack of responsiveness in the therapist, became extremely annoyed and hurled a wooden block from point blank range. On other occasions it was quite apparent that kicking, biting, and scratching were being exercised as a defence against loving impulses. This was probably most apparent when on one early occasion the patient nearly kissed the therapist but turned it into spitting.

IV. How much Bodily Contact? In adult analysis bodily contact with the therapist can be talked about but it is seldom considered wise to permit any real bodily contact with the patient. This may not be the case in psychotic adults and certainly cannot be the case in child analysis in the pre-school age. No rules can be set down but an attempt to have the child use toys as a substitute is helpful. Acting-out a role of a bad child day after day becomes difficult work but finally the child changes the pattern of the play when the problem is worked out. Out of this more concrete play acting the imagination with its make-believe people gradually develops; and as speech becomes more available the task of role-acting lessens. I was asked by the child to wipe her bottom after defaecation. We talked about her wish and the pleasure her bottom might feel and she made a passing attempt with the paper, jumped to the floor and moved on to new play activity.

V. How much Education? Certainly more than in adult psychoanalysis. I continually put her thoughts into words and she learned many words from me. As time went on I helped her to use certain materials in ways she had not discovered. Concern over abuse of materials or the room sometimes did crop up, i.e. plug-

ging the toilet, cutting the mattress cover with scissors. On one occasion we came into the therapy room only to find four one-gallon jars of finger paints, and Patsie was in a pretty party dress. From then on I made sure I checked the room before the patient arrived.

Very close to this problem of how much education is the problem of making interpretations understandable to the patient. At first Patsie seemed confused and sometimes very angry at my interpretations. Much of this I felt was because she could not understand them and because I was not skilled enough to make my interpretations simple and brief. Through repetition it became apparent that we both learned how to understand each other. To become understood is the essence of analysis and learning and analysis are inseparable.

VI. Therapist's Reactions. Seeing a child of this age under these conditions is a very different experience from seeing one's own children of the same age and from seeing children less frequently in psychotherapy. A lot of analytic concepts seemed grossly over-determined, when observed in other settings. The pace, intensity and depth of the experience was on occasions almost overwhelming. Through this experience Mrs. Klein and her frank writings became very meaningful. Anna Freud's discussions of the perversity of infancy and early childhood seemed dilute in comparison to the experience with this patient.

The great concern of the therapist early on was that the child might try to act with other adults the way she acted with him. Might a small child not be demoralized by the accepting attitude of an adult for perverse and delinquent fantasy and play activity during the therapy interviews? Even at 4½, in a child with I.Q. 80, the effect of such treatment, as reflected in the home and at school, was actually one of gradual increase in self-control. This, more than anything else, convinced me that the child understood the therapeutic significance of our special and unique relationship. The therapist recognizes the catalytic effect this experience had for his own personal analysis and found it to be of a very different quality from the effect that adult patients in analysis had on him.

As a practical method of treatment in a general paediatric hospital child psychoanalysis has a very limited application.

As a method of observation of the behaviour of a pre-school child it is particularly revealing, in that it supplies an understanding of the motivation for that behaviour, through knowledge of the fantasy life of the child.

As a learning experience for the therapist it can help to develop a richer and more profound understanding of children, and stimulates in the therapist the reassessment of his own early childhood experiences.

I wish to express my gratitude to Dr. W. Clifford M. Scott who supervised the analysis of Patsie.

Résumé

L'auteur décrit les problèmes qui se sont présentés au cours du choix et du traitement d'un enfant de 4½ ans par la méthode psychanalytique. Une fillette qui présentait des symptômes dysphasiques et des troubles du comportement fut soumise pendant plusieurs mois à des séances thérapeutiques presque quotidiennes. Le matériel des 26 premières entrevues est rapporté et discuté ici. Les diverses formes d'anxiété qui apparurent ainsi que les défenses qui leur furent opposées sont décrites en détail. Certains points pratiques, émergeant comme des leçons à tirer d'une nouvelle expérience, servent enfin de point de départ à l'auteur pour discuter de la validité du traitement ainsi que de ses réactions personnelles.

DIFFERENCES BETWEEN THE PLAYROOM USED IN CHILD PSYCHIATRIC TREATMENT AND IN CHILD ANALYSIS*

W. Clifford M. Scott[1]

Introduction. Knowledge of child psychoanalysis has two uses besides that of teaching one to analyse children. First, some of its methods may aid us in planning new experiments in the treatment of psychotic adults. Secondly, and perhaps more importantly, knowledge of child analysis is helpful in analysing the transference and transference neuroses in adults. When seeking to obtain maximal results in the analysis of adults, it is necessary not only to remove the infantile amnesia, and to reconstruct the period of infantile development, but also to deal with the implications of analysis not having occurred during childhood by constructing what analysis would have been like had it occurred during that period.

Psychoanalysis of children presents a difficulty not present when working with adults—it demands physical as well as emotional stamina. To treat a 3-5 year old child may mean sitting on a very low chair or on one's haunches for an hour, except for the very many times when one moves one's position in order to watch what the child is doing. This is fatiguing.

In this paper I am endeavouring to outline some of the physical requirements for the psychoanalysis of children.

Children are usually treated in a corner of a doctor's office or in a special room. Such special rooms have during the years changed from rooms which were a compromise between a schoolroom and the type of playroom a child might have at home to a room more specially designed.

The psychoanalytic treatment of adults is in a room designed to facilitate free association by providing three things, a comfortable couch, freedom from interruption, and secrecy. Gradually, during treatment, adults come to appreciate more and more the significance of these three things, and the value of each of these factors is appreciated by psychiatrists who offer treatment comparable in one way or another to psychoanalysis.

In the psychoanalytic treatment of children comparable facilities can be provided. Free play activity, within limits which gradually become defined during the treatment of each child, corresponds to free speech or free association in adults. The provision of a room with special features and containing objects which, though simple, may become the basis for expressing both complicated activities and complicated fantasies, corresponds to the provision of comfort for the adult. The regularity, the continued freedom from interruption, and—and this, in my opinion, is most important of all—the provision of a private drawer containing all the small objects used in the treatment of a given child, which is unlocked at the beginning of the interview and locked up at the termination of each interview, corresponds to the privacy and secrecy promised the adult. Only slowly does the child come to believe in the secrecy and in the privacy of the contents of the drawer. In so doing, he comes to trust the relationship between himself and the analyst in a way in which he has previously trusted no relationship.

Very little has been written either about the room used in the psychoanalysis of children or about the rooms used for other types of therapy. Klein[1] described the setting in which she developed psychoanalytic play technique, and commented on the significance and simplicity of various aspects of the toys and the room, stating:

*Presented as part of the Child Psychiatric programme at the annual meeting of the Canadian Psychiatric Association, Banff, 16th June 1960, preliminary to a paper by Dr. Taylor Statten: "Early Stages of the Psychoanalysis of a 4½ year old Girl". This Journal Vol. 6, No. 5.

[1]Consulting Psychiatrist, Montreal Children's Hospital; Secretary, Canadian Institute of Psychoanalysis.;

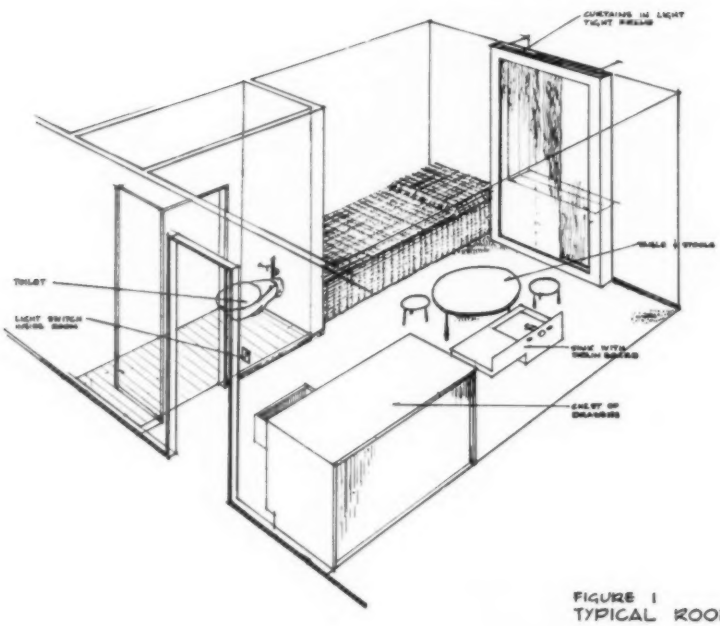

FIGURE 1
TYPICAL ROOM

"The small size of such toys, their number and variety, enable the child to express a wide range of fantasies and experiences. It is important for this purpose that the toys should be non-mechanical, and that the human figures, varying only in color and size, should not indicate any particular occupation. Their very simplicity enables the child to use them in many different situations, actual of fantasied, according to the material coming up in his play."

Lowenfeld[2] has described the type of room she uses which contains, amongst other facilities, several sand trays to be used by several children being treated by several therapists.

The very simplicity of the room used by child psychoanalysts creates a special impression on all those who have not used such a room—it is often thought to be bare, uninteresting, dirty, etc. Nevertheless, a child soon recognises it as a special place where a special type of work and play goes on. Eventually, the child recognises this as something he comes to call by his own special name to distinguish it from other types of activity. Only as he grows up will he discover that it is called "psychoanalysis" and that the psychoanalyst earns a living by treating many people, young and not so young, in a similar manner.

Description of the Room (Figs. 1, 2, 3). The room is square or rectangular*. It has a door which will lead into a hall or preferably a room where the person who brings the young child may wait. If the door is heavy and solid, it will be more soundproof. It should fit tightly, especially at the bottom, so that it will be lightproof. The window, if high above the ground, will have to be made safe. For instance, the opening may be limited to a foot or so, and outside there should be a strong screen so that objects cannot be thrown out. If the panes of glass are small, they are more easily replaced if broken. If they are made of armoured glass, so much the better.

*The one in use at the Montreal Children's Hospital is approximately 13 feet by 11 feet.)

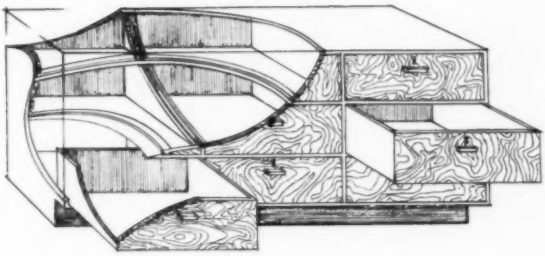

FIGURE 2
SECTIONAL VIEW
OF BUREAU

An important feature of this window is that it should be possible to black it out absolutely. This can be done most easily by a combination of blind and curtains. A blind may be drawn over the whole window, and curtains, which have been fixed tightly to each side of the valance box (which is not only above the window but all round it) should overlap considerably when closed, producing absolute darkness so that a child can play at "day and night". Children who have nightmares or night terrors may wish to play at "day and night", and as long as there is even one spot of light showing, this will represent a night-light for them, and will allow them to orientate themselves, whereas if even for a few seconds a room can be darkened absolutely, the type of disorientation or the type of hallucination which has appeared at night may either reappear or may be more easily enacted.

In the middle of the room there will be a small low table and at least two chairs, one for the analyst and one for the child. A small low couch with a blanket may be in one corner. In another corner there may be a small walled-in lavatory with a door that can be closed and opened by the child. This is a tremendous convenience in that it provides a lavatory which, while outside the playroom, can be entered from the playroom. Having to leave the playroom to reach a lavatory along a hall is very disruptive. With small children, a pot will of course be necessary, and this may be kept in the lavatory when not needed.

A sink with a small draining board for water play is needed. This will either have to be lower than usual, or a small six inch stool will have to be provided for small children. The one tap should allow only a small stream of water. The tap must of course be easily opened and closed by the child. A water source which provides neither too cold nor too hot water is essential. Some type of mixer in the supply outside the confines of the room is necessary. A plastic pail and two floor cloths (one for the child and one for the therapist) are essential. One

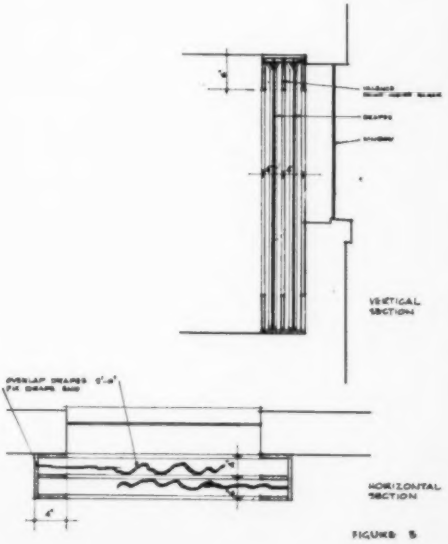

FIGURE 3

towel, not too large as it may have to be changed often, is necessary. A roll of paper towels and a roll of toilet paper present difficulties when the child wishes to use the whole roll. A small supply of each is preferable.

The electric light should be flush with the ceiling and should be covered with a grille which a ball can hit without breaking the light. The best heating is by flat high wall electric radiators out of reach of the child. The usual type of radiator will soon be filled with plasticene, wet paper, etc.

The floor should be non-absorbent and, if covered with lino, should be well waterproofed around the edge.

It is better if any cupboard which holds an extra supply of toys, etc. is not inside the playroom.

Description of Contents. The chest of drawers for toys should be firmly fixed to the wall, and should contain as many drawers as there are children in treatment. Between interviews, each child's toys are locked in his own drawer, the analyst keeping the key. The drawer should be so well made that when it is taken completely out of the chest and emptied of toys, it may be used by the child as a table, as a boat, a train, etc., etc. Consequently, it will have to be strong enough to be sat on, stood on, and placed in all possible positions. The chest should be so made that there is no possibility of the child getting into the top of the drawer underneath when his drawer is removed. In other words, the space into which the drawer fits is absolutely simple and uncomplicated, as is the drawer itself. The size of the drawer will, of course, vary—the larger the playroom, the larger the size of drawer which can be allowed. The size I prefer is 9" x 2'6" x 1'6".

The toys which are contained in the drawer are small and allow the expression of a wide range of activity and fantasy. It is important that the toys should be simple and non-mechanical. The human and animal figures should also be simple. The human figures, of two sizes, should not indicate too strongly any particular occupation. The animal figures and the human figures will be used to represent any kind of animal or human being or animal or human activity. The toys may be of wood, metal or plastic. Plastic materials are easier to obtain nowadays. Usually, two or three of each type are sufficient.

The list is: People (men, women and children); animals (dog, cat, horse, cow, sheep, pig, hen); cars; trains; planes; horse-drawn vehicles; trees; houses; fences. Additional tool-like appliances, such as: wheelbarrow; hand-drawn cart; lawn-mower; etc. may be added. This list could become endless. The point is that a few simple objects will allow the expression of activity and fantasy. Almost any toy may be used for almost any purpose.

Other materials needed are: sheet of heavy wrapping paper; cardboard; quarto sized pad of white paper for drawing; several sheets of coloured paper; soft pencil; pencil sharpener; eraser; box of crayons; small paintbox containing a few colours; two small brushes; box of small wooden blocks of various shapes; pair of blunt scissors, two needles; spools of black and white thread; a few pieces of cloth, white, black and coloured; plasticene; blunt knife; marbles; small rubber ball; small tin of paste (the semi-solid kind); set of 4-6 small cardboard boxes which can fit into each other and may also be used separately of course (the stronger these boxes are the better); small china or plastic teaset for pretend meals, with small knives, forks and spoons.

Such a room lacks any toys that are shared between children. (Anything that is shared will produce unnecessary difficulty). It does not include a large doll, a sand tray or a blackboard, all of which are frequently provided in playrooms of other types. A doll may be produced

later if it seems to be important. A blackboard, being part of the wall, will tempt the child to write on other parts of the wall and to demand that messages be left at the end of the interview for others. If writing or painting is on paper it can be stored in the drawer. Sand is too dangerous both to child and analyst when the child becomes destructive. Once in an eye, sand is difficult to get out. Plasticene, paper—wet or dry—etc. can easily be used to symbolise earth.

Another great asset is a fireplace, only to be used if playing with fire is of great importance—as it sometimes is. (Sometime some insurance company may give a grant for the study of children who are or will become arsonists.)

Young children obviously will not be able to use some of the toys listed, but certainly with four year old children all toys can be used. Older children may make no use of some of the toys for months.

Apart from my personal psychoanalysis, I obtained my greatest stimulation, both to observation and to learning, during the psychoanalysis of the youngest children I have treated. The treatment of a child is more and more frequently becoming part of training in psychoanalysis, regardless of whether the student intends to practise child analysis or not.

During child analysis what in adult analysis can only be reconstructed is vividly shown. As more adults in psychoanalytic treatment come to know about child psychiatry and child analysis, and to reconstruct or remember their childhood, they begin to construct what treatment would have been and what it would have done for them had it taken place in childhood. Similarly, children sooner or later begin to wonder what would have happened had they had to wait until adulthood for the treatment from which they are benefitting.

Only after discovering what use a child can make of psychoanalytic treatment do we realise both the values and the handicaps of methods which offer less. This realisation occurs also during adult psychoanalytic treatment when ideas of what psychoanalysis can offer in comparison to the satisfactions and frustrations of other types of psychotherapy become clearer.

Only after one has tried to treat a child in the situation described will one experience what happens when he begins to feel that the time, the place, the toys, the drawer, and you, are for him and him alone, and at the same time that they are providing him with something he can keep within himself and use elsewhere.

Résumé

L'auteur décrit en détail, en même temps qu'il en explique l'utilisation et les motifs thérapeutiques, le cabinet et le matériel nécessaires à la psychanalyse des enfants. Il insiste sur les facteurs de confort, d'isolement et de secret qui sont le propre de toute psychanalyse. Les jouets deviennent les moyens d'expression de l'enfant et il les laisse à la garde du thérapeute dans un tiroir bien à lui. Les fantasmes doivent pouvoir être joués librement et en toute sécurité.

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PSYCHOTHERAPY OF ADOLESCENTS: SOME CONSIDERATIONS ON TECHNIQUE

DENIS LAZURE, M.D.[1]

Empathy, which is a state of alertness resulting from a continual process of projection and introjection, is a prerequisite for anyone who treats adolescents. And with such patients, empathy implies:

1) The capacity for the therapist to maintain a minimum of dissatisfaction vis-à-vis the status quo, which is necessary if he is to comprehend the confusion and the idealism so often responsible for the adolescent's rebelliousness but which must avoid the danger of making the therapist a potential ally of the patient's pathological ego;

2) The ability to react with a minimum of anxiety to the manifestations of "raw" instincts, characteristic of the psychotic or antisocial adolescent;

3) The spontaneity which will permit intuitive interventions, reaching the current "ego state";

4) A genuine respect for and confidence in the strivings towards maturity which are present in any adolescent.

Effective communication is essential to any psychotherapy; the therapist must be familiar with the adolescent's lingo. His own style must neither be pedantic nor patronizing. As a rule, silence is poorly tolerated by the adolescent and in the initial phase of the treatment it is advisable to prevent it or else to break it even if it means encouraging productions which on the surface appear trivial.

Initial Interview. In his first encounter with the patient, the psychiatrist seeks to establish a good rapport as well as to properly assess the psychopathology. There is always a danger of fostering one pursuit at the expense of the other,—either by adopting a seductive, overprotective attitude which aims at an "early positive transference" or by submitting the adolescent to a barrage of questions and comments in the hope of eliciting "significant material".

If the parents accompany the adolescent, it nevertheless seems preferable to first see the patient alone even when little is known of the problem. He is then asked why he thinks he has been brought to a psychiatrist, what he was told about the visit, how he feels about it, whether he sees any problem and if so to talk about it. In the case of a neurotic adolescent, the frequent discomfort created by the symptoms will bring about a strong motivation for help and the first interview should present no great difficulties.

On the other hand, the pre-psychotic adolescent will often suffer from a paralysing anxiety centered, for example, on the fear of becoming "crazy" which usually refers to the fear of impending loss of control over those overwhelming impulses so peculiarly threatening to the adolescent. Here one should avoid either minimizing such a fear or responding with excessive concern.

Towards the end of the interview, it is suggested to the adolescent that together you meet with the parents to find out their own version of the problem, to see how their attitudes may contribute to the patient's difficulties. Such a "family interview" is extremely helpful in that you can observe the child-parent interaction and even sometimes interpret to both parties how their respective behaviour contribute to the total problem. It is wise to elicit from the parents their expectations from the treatment and to show them the nature and goals of the work you will be doing with their child.

The therapist's position during such a conference can be described as a "moderate alliance" with the adolescent: one should not increase the parents' feeling

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of guilt and at the same time should be aware of their suspiciousness towards this new "competitor". The parents' cooperation will be necessary throughout the treatment and a well-conducted "family interview" can do much to decrease the parents' tendencies to sabotage the therapy in order to show you that you are "no better" than them.

It should be clear to the adolescent, right from the beginning, that throughout the treatment, the therapist will not deal with the parents unless this has been discussed with and agreed upon by him and it is wise to limit those dealings to a minimum until the therapeutic relationship has been firmly established. The value of those conferences with the parents will largely depend on the timing: when properly dosed they can act as a powerful catalyst for the treatment.

The Neurotic Adolescent. From a close study of the case histories of neurotic adolescents there emerges recurrently the following family constellation:

The parent of the same sex being perceived as rigid, authoritarian and threatening, whereas the one of the opposite sex is seen as kind, tolerant and even seductive. One is tempted to interpret such a finding as a confirmation of the common psycho-analytic view that adolescence basically promotes a resurgence of the oedipal conflicts.

Thus we find, in the early stage of therapy, a need for the adolescent to express bitter criticism towards the parent of the same sex: if the patient has difficulty in verbalizing such hostile feelings, it should be one of the first tasks of the therapist to bring about the abreactive process, a pre-requisite to the next phase which will consist in relieving guilt feelings. It is only then that a true, positive, working relationship can develop between the young patient and the therapist.

However, in dealing with a younger adolescent, this technique must be used with caution because of the still strong, dependent, libidinal ties to the parents. If the pathology is mostly of the obsessive-compulsive type, one should also keep in mind that the tyrannical superego will poorly tolerate a too intense or too premature discharge of hostility toward a parent.

With the adolescent, one continuously makes use of the positive elements of the transference but it is seldom necessary to interpret them: to do so with the adolescent boy is apt to provoke a sudden withdrawal either because of a stirred-up homosexual panic or because the strong dependency would inflict a narcissistic injury thereby hampering his search for ego autonomy. With the adolescent girl, too much emphasis on the positive transference could lead to an excessive stimulation of the erotic phantasies and cause severe blocking. When faced with an unduly strong dependency, it is helpful to introduce less gratifying attitudes, to inject a judicious dosage of frustration.

In interpreting the negative manifestations of the transference, one should keep in mind the natural sensitivity of the adolescent who is prone to feel reprimanded.

The classical three-dimensional interpretation which relates the present behavior or affect to 1) the current conflict, 2) the transference neurosis and 3) the infantile neurosis—is seldom indicated except in a formal analysis or in the final stage of a long and deep psychotherapy.

The two-dimensional interpretation tying up the present problem to a conflict from the past seems to be most helpful to the neurotic adolescent: with the psychotic, on the other hand, it is often too anxiety-creating and can cause further regression with feelings of depersonalization.

The one-dimensional interpretation or "clarification" is very useful at the beginning of therapy as it serves to bring out in the open the underlying affects and conflicts.

Any attempt at analysing and substituting pathological defenses should be made with the constant thought that the adolescent's defences are most fragile than the adult's, making sure that the therapeutic contact will be long enough so that the patient has time to edify healthier patterns of defence.

Displacement, denial and projection should be the first defences dealt with, as they so obviously distort the reality testing. On the other hand, repression and reaction-formation which have been particularly cultivated during latency, are now strongly assimilated to the character and are often necessary for the sublimation that the adolescent seeks to achieve in so much of his activities.

The ego during adolescence is largely concerned with finding its own identity; very often, the therapeutic dependency, if it is too intense and prolonged, is perceived as an obstacle to the achievement of such a task. That is why, once the ego-dystonic symptoms are removed, the adolescent will wish to discontinue treatment and in most cases it is preferable to go along with that desire and thereby express your confidence in his innate capacity for healthy growth.

The Pre-psychotic and Psychotic. In the same way that we have come to accept the general occurence of neurosis during "normal" childhood, we are beginning to wonder whether "normal" adolescence does not imply transient psychotic or prepsychotic states and whether adolescence cannot be characterized as a "psychosis incipiens".

During an acute schizophrenic episode, the adolescent should be hospitalized. Paranoid resistance to psychotherapy is almost the rule but it will quickly subside if the milieu responds to suspicion with attitudes and deeds which gratify the patient and if the therapist makes himself available in a genuine and flexible way, rather than remaining an artificial personage who can be seen only in his office at given hours.

It is important that the adolescent feel that his doctor has a reasonable degree of authority when it comes to the daily hospital routine. Otherwise, the adolescent's narcissism does not allow him to identify with a therapist who would be "castrated" by a rigid, bureaucratic hospital set-up; furthermore, the patient would then attempt to manipulate those who are actually powerful and thus would act out his conflicts mostly outside the weakly-catheted therapeutic relationship.

The therapist who is overly eager to uncover "dynamic material" will not reach the psychotic adolescent. On the other hand, a too passive approach will be interpreted as lacking in interest. The patient is not so much impressed with the therapist's verbalizations as he is with his timely presence; his calm but sympathetic understanding will serve as a reassuring strength, counter-acting the threats of the disintegrative processes.

Once the psychodynamics are well grasped and the doctor-patient rapport well established, then the defensive aspects of the schizophrenic withdrawal must be interpreted. In doing so, one can refer to events related in previous sessions or known from the history, whose traumatic effects produced a demonstrable evasion from reality. When delusions (usually paranoid) form the main symptom, one should try to identify the significant figure who is at the core of the delusional thinking and to have the patient say as much as possible about his relationship to that person. Keeping in mind the crucial role of homosexuality in the formation of paranoid symptoms, it is then logical to expect the parent of the same sex to be most implicated in the patient's pathology.

Treating adolescents, one often meets with tenacious and absolute silence during the session. If such a silence is of a hostile, paranoid type it is better to shorten the formal sessions and to seek brief, informal contacts around occupational or recreational activities. If the

silence results from a paralysing anxiety, it is useful to suggest non-verbal means of communication, such as writing, drawing, modeling, etc. . . . and to respond to the patient's productions even if your monologue has to go on for many sessions. Loaded questions such as: "What is on your mind" should be used with caution, as its very vagueness only emphasizes the patient's feeling of confusion, when it is not plainly interpretated as a reproach for his "bad" thoughts!

However, if the adolescent expresses himself in primary processes of thinking with a definite, anxious wish for communication, the therapist should enter into the same mode of expression without having to "translate" his interpretations into conventional language. (Sechehaye's "réalisation symbolique".)

If interpretations of a general nature can be useful with the neurotic they become meaningless to the psychotic adolescent, who maintains "a direct line" with his unconscious and can respond so well to a direct analysis à la Rosen.

The Anti-Social Adolescent. We are concerned here with the adolescent who is often called "delinquent" but whose delinquency is a symptom of a severe character disorder; some clinicians prefer the term "psychopathic delinquency".

The delinquent adolescent will not usually feel any need or wish for therapy except perhaps if following his arrest he is given a choice between incarceration and psychiatric treatment in an outpatient clinic. Once he is confined to a "trade school", he may also accept psychotherapy as a break in the daily monotony or as something he can use to get his term reduced. Obviously, such an attitude is a far cry from the motivation which we usually believe to be a prerequisite for effective therapy. The point is, of course, that just as resistance fluctuates in the best-motivated patient once the treatment has begun, so does the motivation in the most resistive patient.

Aichorn's technique developed with Viennese delinquents still remains an inspiration for all workers in the field. In the first phase of the treatment, the therapist strives at becoming part of the adolescent's ego-ideal. Instead of the classical transference, a narcissistic relationship develops, based not on the authority of the therapist or respect for him but on a genuine admiration that the delinquent feels for the adult who can outwit him on his own ground but without creating fear or humiliation.

In this fashion the adolescent's mask of superiority comes down and then appear feelings of inadequacy (along with castration fears) previously repressed, which will motivate him to meet the therapist halfway—partly to appease him but also because the growing admiration allows for a positive relationship. He now feels a strong need for the therapist who might help him with his confusion and anxiety; the therapist becomes an autonomous individual and no longer a narcissistic appendage.

In view of the impulsiveness of such a patient, the therapist should be particularly alert in offering gratification at the appropriate time; indecisiveness on his part will stimulate the patient's acting out followed by hostile withdrawal.

Manifestations of negative transference as well as anti-social behavior outside the sessions should be analysed as soon as they occur.

Counter-transference feelings will continuously be tested out. For example, when the adolescent boasts about his unacceptable behavior, the therapist must avoid moralizing or becoming too alarmed: with genuine interest, he should discuss such behavior openly, interpreting its genetic and transferential motivations as well as its self-destructive, punitive aspects.

Résumé

Dès le premier contact avec le psychiatre, l'adolescent doit sentir que c'est

lui, et non les parents, qui sera le principal artisan de son traitement. Vis-à-vis des parents, le thérapeute maintient une "alliance modérée" avec le patient.

Chez l'adolescent névrosé, le déblocage de l'hostilité surtout à l'égard du parent du même sexe doit être favorisé dans la première phase de la thérapie.

L'interprétation analytique à trois dimensions est rarement indiquée. Le caractère fluide des défenses de l'adolescent exige certaines mesures de précautions qui sont indiquées.

La technique qui veut que, sur le plan génétique, l'interprétation s'attaque d'abord aux couches superficielles, doit souvent être modifiée quand il s'agit d'un adolescent psychotique. Quelques aspects du problème du silence sont abordés. L'auteur croit que les méthodes de Sechehaye (réalisation symbolique) et de Rosen (analyse directe) sont particulièrement efficaces avec l'adolescent schizophrène.

L'article se termine par des observations sur le traitement de l'adolescent dont la délinquance résulte de troubles caractériels graves; il endosse les vues de Szurek et Johnson (surmoi troué) et la technique de A. Aichorn.

PHOBIAS IN CHILDREN

F. A. DUNSWORTH, M.D.[1]

Persistent, irrational and usually overwhelming fears of situations or objects during childhood may be based on several mechanisms. These mechanisms include:

1. A displacement of anxiety, e.g. anxiety felt on separation from an overprotective parent may be displaced into a "school phobia".

2. From a transient stress reaction, e.g. a fear of travelling in an automobile following an accident ("traumatic phobia").

3. As a specific symptom of an anxiety neurosis or "phobic reaction".

4. As a vague symptom of a more severe psychiatric condition, e.g. pseudo neurotic schizophrenia.

5. Associated with various specific defects, e.g. mental retardation, specific reading defects, deafness, etc.

In a consulting practice and experience in a Child Guidance Clinic we are impressed with the frequency of phobias as a presenting symptom of neurotic reactions in children. In a previous publication[(2)], we outlined our criteria for school phobias and our treatment approach; it was this study that aroused our interest in establishing the frequency of this particular phobia and led to a continuing study of all phobias.

For three years in the Halifax City Schools we have found school phobias an important factor as a cause of "non-attendance". (Fig. 1).

In a study of 100 consecutive referrals at the Child Guidance Clinic from September 1959 to March 1960, we felt 34 youngsters showed "neurotic" reactions (this included not only clear-cut neuroses, but also "primary behavior disorders with neurotic traits"). We were surprised to find 22 cases showed phobias, 12 of them showing school phobias. (Fig. 2).

The age distribution of these 22 cases from the Child Guidance Clinic shows a wide spread. (Fig. 3).

In 56 consecutive cases seen in a private consulting practice, the wide age distribution is reduplicated but the male/female ratio different. (Most studies give a much higher incidence in girls). (Fig. 4)

The higher incidence of phobias in private practice (Fig. 2) is probably associated with the type of patient referred. Generally speaking, Child Guidance Clinic referrals include a higher proportion of "conduct disorders", referrals from schools, agencies and the courts. Most of the cases seen privately are referred from physicians who naturally have been consulted about physical complaints. We feel that the clinical pictures of neurotic reactions are similar in both groups but to understand the problem of phobias in children we have learned that we must separate our cases into three groupings, that fall into three broad age groups.

1. *Preschool and early school age*: Phobias in this age group seem based on separation anxiety. The actual symptoms may only appear when the child starts to school but frequently these children have never been "separated" before – they have remained close to home, often clinging to an ambivalent mother and the legal requirement of school attendance forces the separation. Other phobias in this age group may include fear of other children, of strange adults, or of animals.

Clinical judgment is very important in assessing these cases. Many children have fears that can often be considered "normal" or transitory, associated with the age of the child. The difficulty lies in distinguishing between these "normal"

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Figure 1.

Halifax City Schools	(Sept.-Oct. only) 1957	(Sept.-June) 1958	(Sept.-May) 1959
Non-attenders	143	69	67
Definite school phobias	11	13	7
Suspected ,, ,,		18	6
Total School Phobias	11	31	13

Figure 2.

	C.G.C. Patients	Private Patients
Total Number	100	56
"Neurotic"	34 (34%)	29 (50%)
"Phobic"	22 (22%)	24 (43%)
Male/Female ratio	4:18	11:13

fears and the pathological fears that require immediate attention.

Treatment of phobias in this age group depends on many factors. It is our impression that resolution of the more obvious psychological familial difficulties by working with cooperative parents is more important than long continued psychotherapy with the child. The commonest difficulty is the neuroticism of the mother who shows overprotection of the child which is an overcompensation for her rejection of him. In a few cases we have found the mother exploited the mutual inter-dependency of herself and her child as a weapon against her husband. In mothers with deep-seated neurosis, individual psychotherapy is often indicated but unfortunately is sometimes refused. We sometimes are forced to lower our therapeutic sights and in these "uncooperative" cases try to insidiously intervene between the neurotic mother and her child by using extra familial contacts such as the school and group activities. Occasionally we have found fathers

Figure 3.

Phobics — (Child Guidance Clinic)

Age	6	7	8	9	10	11	12	13	14	
Male		1		1			1	1		(4)
Female	3		2	2	3	2	1	4	1	(18)

Figure 4.

Phobics — (Private)

Age	3	4	5	6	7	8	9	10	11	12	13	14	
Male			1		3	2	1				3	1	(11)
Female	1		3	1		1	3	3	1				(13)

can be helpful, unfortunately in usual child psychiatric practice fathers are frequently left out of therapy.

2. *Middle school age*: In addition to the "separation" anxiety as in the younger group, we find in this group an element of projected hostility. We have found a fear of "a cruel teacher" or getting beaten by rough playmates a frequent "reason" for not attending school. There are other displacements too, but clinically we rarely find the sexual conflicts that the literature would lead us to expect.

The commonest phobia in this age group is a school phobia. We have already outlined our treatment approach but feel we should restate our main criteria. Untreated phobias tend to worsen and spread, therefore if the child is avoiding an important situation, e.g. school, with the cooperation of the parents and the school the child should be returned *immediately* to school. Firmness at the first appearance of the school phobia is much more important than prolonged psychotherapy at a later date. The next step is therapy with the child and casework with the parents in an attempt to understand and rectify the psychopathology present.

Nine year old Judy had been ill for a week with a viral infection. When it came time to return to school she developed nausea and vomiting and fearfulness. The family physician after two days felt the etiology was psychological and referred her for evaluation. Following our custom we treated her as an emergency and saw her the next day. Both parents were involved in returning the child to school that same afternoon (after our rapid preliminary assessment had been completed). With the cooperation of the parents and the school plus the school mental health liaison officer, she returned to school that same afternoon and her more marked symptoms abated in four days. Unfortunately the parents were loathe to continue contact with us after Judy had readjusted to school and after six interviews stopped attending the Clinic. We felt we had modified the neurotic parental attitudes but not really changed them.

This rapid return to school (or to facing any other phobic situation) does not work in those cases where a serious ego defect is present, or where the parents are markedly uncooperative. In such cases counter-phobic pressure may do more harm than good and may lead to a marked panic state or deeper regression.

Carl, age 11, had been truanting for a year when he first came to our attention; in fact with the family, consisting of father and mother, moving back and forth from the City to their original rural home, school attendance was extremely irregular for years. In that rural area there was little supervision or evaluation of school attendance and we could not be sure if his non-attendance was due to truancy or to his phobia but we suspect the latter cause. Carl's father was probably a simple schizophrenic who, when he did not have regular labouring work, would stay in bed most of the day. Mother "couldn't do anything" with Carl when he started staying in bed with the father. During four months placement by the Juvenile Court in an institution for boys, Carl conformed and attended school but on return home he regressed and finally our contact ended with a mental hospital commitment, diagnosis simple schizophrenia.

3. *Adolescent age*: In this group the psychodynamics are much more malignant and therapy results much poorer. We find many of the phobias are part of an obsessive compulsive picture. In the older literature phobias were considered either a part of the "anxiety hysteria" syndrome, or a part of the obsessive compulsive neurosis. Now with the American Psychiatric Association classification, phobic states are listed separately. In our opinion a phobia is a symptom, like anxiety, and can be present in many psychiatric syndromes. For example in the adolescent group it is not unusual to find a case referred for "phobias" to be suffering from a schizophrenic condition, usually of the pseudo neurotic type.

We have seen relatively long standing phobic states. They require prolonged therapy.

Jackie, age 15 (8, when he first was referred) became worried every time his parents went out. A neighborhood couple had been killed in a car accident shortly before these symp-

toms appeared and Jackie feared for his parents' safety since if anything happened to them he was preoccupied with the fear of being then alone. He established compulsive rituals before leaving for school. Later he said "then I felt nothing could happen to mother while I was away". Though at times in the past few years he has had moderate gastro intestinal upsets and anxiety attacks associated with school, he has rarely missed school and has graded every year. However he has required weekly psychotherapeutic interviews for years to maintain himself. His phobic mother has improved with psychotherapy and is now continuing with casework interviews.

In adolescents with an acute onset of phobias and anxiety associated with marked stress the prognosis is usually very good.

Jimmy, age 14, had accidentally shot a playmate while rabbit hunting during the Christmas holidays. Even though he was completely exonerated at the inquest he became sleepless, anxious and mildly depressed. When it came time to return to school his symptoms worsened and he couldn't remain in the classroom. A few supportive interviews, and the judicious use of tranquilizers and hypnotics in combination with very positive encouragement from his family, the family of the victim, and school personnel led to abatement of his symptoms in less than two weeks. Follow-up six months later revealed a return to his previous healthy adjustment in all spheres.

Since we have often received referrals of children with physical handicaps (deafness, etc.) or retardation as "school phobias", we insist on a complete evaluation in every case. The history should clearly delineate if this is a solitary or multiple phobia as well as the age of onset – as the dynamics and the therapeutic approach seem associated with the age group of the patient.

An evaluation of the child's ability to separate and be independent, to make friends and to be able to go places on his own gives a strong indication of how deep-seated and of how long-standing is the condition. It also helps us evaluate his relative ego strength, an important consideration in therapy and especially important if the resources of the parents in the psychological area are deficient.

In common with most child guidance clinics we have a relatively long waiting list for therapy. This fact plus our experience in recent years has led to the somewhat drastic step of treating *recent* and *acute* phobias in younger children in many unorthodox ways. For example in the first two months of each school year our social worker starts therapy of school phobias with the first telephone contact from the parents. Often in basically healthy families the support felt by the parents from the social work contact is enough to help them to return the child to school and to deal with his problems in a more constructive fashion. Some of the cases in this category never seem to require continued therapy. We have at times delegated these cases to the mental health liaison teacher in the City Schools who with help from the attendance officer has achieved some excellent results. We would stress that this counter phobic approach is primarily indicated in the cases where the onset is recent and acute and the child is in the younger age group with good personal and familial psychic strength. It is thus applicable only after an individual assessment of each case and must not be applied indiscriminately.

Résumé

Les phobies se rencontrent fréquemment comme symptôme névrotique chez l'enfant (entre 65 et 80%). L'auteur les distribue en trois groupes: âge préscolaire, âge scolaire et adolescence, qui selon lui doivent être traités de façon différente. Le pronostic dépendra de facteurs tels que la date de début, la durée de la maladie, la structure du moi chez l'enfant et la coopération de la part des parents.

AN INTENSIVE APPROACH TO BRIEF FAMILY DIAGNOSIS IN A CHILD GUIDANCE CLINIC

M. Albert Menzies, M.D., S. Bodlak, M.S.W., and O. McRae, B.A.[1]

In localities without ready access to a child guidance clinic, the needs for diagnostic consultation are very great. In this province such assistance has been provided to rural areas by a travelling clinic team which visits at intervals varying from two to twelve months, depending on the locality. Occasionally, a family will come to the main clinic for assessment. Consultations are typically coloured by the hope for a difficult problem to be magically solved by an omnipotent clinic team. This is contrasted with the bitter reality that usually the clinic assessment mainly confirms the views already formulated by the less specialized local professionals as to the nature of the problem and provides little or no change in the situation. If the family journeys several hundred miles at considerable expense, the disappointment can be still greater.

As one answer to this problem, some efforts have been made here to provide a more intensive diagnostic study compressed into a period of two or three consecutive days.

Method of Operation. The main theme of this approach is to keep the family in active participation with members of the clinic team throughout the day for two or three consecutive days. The first contact is a joint interview with the child and parents, conducted by the psychiatrist with the social worker sitting in. The child is then seen for two or three sessions by the psychologist and may also have one or more psychiatric interviews without his parents. Meanwhile, the parents participate in several individual and joint interviews with the social worker and the psychiatrist. The detailed procedure is planned in action as the assessment proceeds and according to the needs of the particular case. To facilitate this, the team members confer together once or twice each day. One important focus in these conferences is the determination of goals which seem practical within the limits of the situation. These goals must make allowance for the time limitation and the readiness of family members to attempt clarification and resolution of their problems. Usually the final event is a psychiatric interview with child and parents together, with the social worker assisting. In this terminating session, salient points are reviewed with the family, including the presenting problem, clarifications which they have achieved, the situation at the time of ending and plans for the future.

To enhance the effectiveness of this procedure, we insist upon active involvement of some professional person from the "home town" before and after the clinic study. Before any clinic contact a social history is submitted by a local public health nurse, social worker or probation officer. The assessment is arranged through this local professional person who, in turn, undertakes follow-up help after the family's return home. Usually the local professional personnel have committed themselves to the case before referral and this adds vigour to their further efforts. Two brief case reports might helpfully illustrate:

Case 1. Andrew M., age 15, was referred by the school nurse as withdrawn, immature emotionally, socially and physically, with poor school progress and evidence of a poor father-son relationship. He was the second of four children and the household included an 86 year old invalid maternal uncle. Examination at our base clinic had been recommended previously by our travelling clinic team in a consultative conference.

Andrew and both parents participated in a series of joint and individual interviews throughout two consecutive days. Andrew admitted

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some unhappiness, particularly with regard to his sister Heather and his father. The psychologist found him inhibited, distractible, immature, functioning low in the dull normal range of intelligence, with unexpressed hostility, anxiety, some possible organicity and inadequate inner and outer controls. There was a history of seizures up to age 7 and the electroencephalogram showed a moderate intermittent cerebral dysrhythmia of sub-cortical origin. The neurological consultant saw no need for anticonvulsant drugs at this stage but suggested small doses of Dexedrine.

Both parents were interviewed several times separately and together, presenting a clear picture of a harsh, angry father and an overprotective, inconsistent mother with excessive permissiveness. Father favoured separation of Andrew from them because he felt they would be unable to straighten him out. Mother rejected this plan and was faced with the alternative of taking responsibility herself for firm, consistent discipline. This was difficult for her because of resentment of the harsh discipline of her own parents and her husband, plus the influence of Andrew's pyloric stenosis and surgery at age 3 weeks and spells of losing his breath from age 2 days to 7 years. She considered this overnight and decided to accept Father's suggestion that he leave the discipline of Andrew to her, assisting her only at her request. Mr. M. decided to concentrate on praising Andrew for his accomplishments in order to improve their relationship. In a final interview with Andrew and both parents together, some further cross-ventilation and communication occurred and Andrew suggested some ways in which he might be given more responsibility.

After two days at the clinic they returned home and a full report was sent to the public health nurse who had referred them, plus a copy for the family physician. The situation was reviewed three months later when our travelling clinic was in their locality. A conference with the public health nurse and school principal and another with the family physician elicited reports of marked improvement in Andrew's school performance. Andrew was seen again by the psychologist who had seen him at our base clinic and she noted marked improvement, especially in his feeling of self-worth and his report of things at home. The parents were also interviewed again, together and separately and the most impressive theme was the growing confidence of the mother as she took over the role of leadership from the domineering father who really was less adequate for this role. At this point the death of the invalid uncle promised more time and energy available to her for her husband and children.

Case 2. Neil W., age 14, was referred by a private psychiatrist because of separation anxiety. The referring psychiatrist proposed that he should be separated from his widowed mother in a distant town and live with relatives in the city with regular attendance at our clinic for psychotherapy. An intensive two-day assessment was arranged for two reasons; first, to consider implementing the proposed plan and second, to do whatever might be possible to help the mother release him from their neurotic tie.

Neil and his mother participated in a series of individual and joint interviews throughout two consecutive days. Neil was ambivalent about clinic help, but mainly resistant to it. Our psychologist found him to be of average intelligence, immature, withdrawn and depressed, with apparent fear of masculine characteristics and no satisfaction in current relationships with others. His mother was also ambivalent about the plan, but more inclined towards favouring clinic help, mainly because of his hypochondriacal tendencies and excessive dependency on her following the sudden death of his father when Neil was 7.

We decided to accept Neil for psychotherapy and support the plan of separation from his mother. When faced with this decision in the final joint interview Neil reacted with intense anger and threatened to run away. We had decided to avoid probing his mother's dynamics too fully, wanting to preserve her ability to maintain a firm stand in support of the treatment plan. The plan was carried out and at the time of writing, Neil was progressing favourably in therapy and had survived a visit home for Christmas vacation.

Discussion. As compared with our usual "single shot" diagnostic assessment, this more prolonged evaluation is more satisfying to the clinic team and holds more potential for a real impact on the family. Increased diagnostic clarification enhances the consultative assistance to the local personnel who referred the case. The intensive clinical experience adds attractiveness to the consultative function which is often regarded by clinic staff as a "poor relation" of the more favoured treatment experience. When a significant change in the family dynamics does occur, this provides great stimulus to further rehabilitation after their return home.

The potential for change is emphasized by Goolishian (1), in his description of this two or three day procedure as "brief

family-oriented psychotherapy". He points out such important features as highlighting of family dynamics and acceleration of family self-rehabilitation. He underlines the impressive change in the dynamic balance of the family without significant personality change in either parent. He quotes follow-up studies as showing considerable improvement, but details on this point are left for a subsequent report. We too have been impressed by the potential for rapid change in reaction patterns of family members and dynamics of the family within the two or three days. This is illustrated particularly by the changes in the mother in Case 1. A similar phenomenon has been experienced by one of us* in another setting involving psychiatric consultation on pediatric inpatients. These children were admitted briefly from out of town to a general pediatric ward, mainly for investigation, and psychiatric consultation was requested. The child and parents were seen by the psychiatrist once every day or two during the one or two weeks in hospital. The changes which occurred in such a short time were quite impressive, with encouraging reports from follow-up studies six months later.

Indeed, this rapid change in family dynamics creates one problem which must be recognized. On the one hand it does facilitate continuing improvement afterwards, but by the same token it might predispose the family to more serious breakdown if insufficiently supported after returning home. This risk adds importance to the active involvement of local professional persons before and after the clinic assessment with as much integration as possible. It also highlights the problem of assessing in action which goals are appropriate for the particular family at the particular time in view of their readiness, strengths and weaknesses. This, in turn, relates to the broader problems of family dynamics and family interviewing which are beyond the scope of this paper. Principles which we have found useful have been discussed elsewhere in a growing body of literature on these subjects, stimulated especially by Dr. Nathan Ackerman (2). Mitchell (3) and Weiss (4) (5) have made recent contributions. Other helpful communications have come from Meyer (6), Bowen (7), and Hallowitz (8) (9). A scholarly description of modification of role in the family has been provided by Spiegel (10).

Since our experience with this approach is still very limited, no claims are offered regarding its effectiveness. Rather it is described here as a method which seems worthy of further study and trial so that its place in the clinic armamentarium might be clarified.

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Summary

This paper is addressed to the problem of consultative assistance by a child guidance clinic in cases from long distances who come for brief investigation. A method of intensive family diagnosis is described, in which the child and both parents participate in joint and individual interviews throughout a two or three day period. Two case illustrations are outlined and some relevant points are discussed.

Résumé

Une méthode de travail de choc combinant diagnostic et directives thérapeutiques s'est avérée pratique et efficace dans un milieu où les patients sont référés de très loin et ne disposent que de peu de temps dans leurs contacts avec l'équipe psychiatrique. L'enfant et les parents sont engagés dans des entrevues individuelles et conjointes échelonnées sur une période de deux ou trois jours. Le travail de défrichement a déjà été fait au point de dé part. L'équipe se réunit fréquemment pour faire le point ou décider de certaines attitudes. La dernière réunion sert à récapituler les faits, à interpréter les observations et à suggérer une marche à suivre.

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A PSYCHIATRIC WARD IN A CHILDREN'S HOSPITAL— THE SOCIAL WORKER'S CONTRIBUTION

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The psychiatric ward for children is a new addition to the hospital. This article reports on the experience of the psychiatric social worker attached to the in-patient unit of The Montreal Children's Hospital: a short-term diagnostic and treatment ward recently open within the framework of the Department of Psychiatry[2]. The therapeutically oriented group environment is of major importance with a well-balanced program including psychotherapy, schooling, occupational therapy and recreation.

The Role of the Social Worker. I will focus on the social worker's contribution in working with parents of emotionally disturbed children hospitalized in the psychiatric ward. The social worker participates in: (1) the intake procedure or pre-admission interviews; (2) the ongoing work with the parents during the hospitalization and post-discharge; (3) the concurrent group work with the parents of the children hospitalized on the psychiatric ward; (4) the family interviewing technique jointly with the ward director as a clinical assessment.

In addition the social worker attends ward rounds, administrative discussions to deal with program and staffing, case conferences to formulate the diagnostic and treatment plan, which are also used as teaching seminars.

Although psychiatric services for children have become more accepted, and the referral to the Department of Psychiatry is no longer felt to be threatening and looked upon with the negative attitude of earlier times, a certain amount of fear and apprehension is still frequently encountered in parents of children who are referred to the in-patient unit. It is fairly common to find considerable resistance. Due to the inner conflicts arising from deep-rooted feelings about mental illness, and their guilt arising from the rejection of help, the parents attempt to deny and minimise the problem for which hospitalization is recommended. Parents must be helped to recognize and understand these feelings.

Parents' Attitudes in Pre-admission Procedure. The variety of attitudes manifested by parents when they initiate contact with the social worker and the way they request help may be viewed as a preface to the theme which will unfold later during the total diagnostic and treatment process. Parents may protest about the time required for the diagnostic evaluation and initial treatment. They may fear a too long exposure of their own feelings and show an unwillingness to become involved in their child's treatment. They prefer to maintain the status quo, the very same reason why the child was referred to the in-patient unit. Although previously they have been given a diagnostic statement, they may present a confused picture, often seeming eager to understand only the etiology of the disorder and constantly seeking reassurance. If parents are clear about their child's condition they may approach the hospitalization with an overall feeling of 'last chance'; "We have tried everything, now let's see what the psychiatric ward can do about Jimmy's behaviour". There is often such hopelessness and despair in their presentation that the social worker has difficulty in being sufficiently reassuring and supportive.

Parents often express concern over the hospitalization itself, fearing that the child will be "at his worst" while on the ward, or that he will not show his "real self" and we will see him "at his best". They are afraid that their child will be affected by the behaviour of other chil-

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[2]Acknowledgment is given to Dr. Hyman Caplan, Assistant Director, Department of Psychiatry, Chief Psychiatrist in charge of the in-patient unit, for his guidance and support in the writing of this paper.

dren. "That ward is not what my child needs, the other children are crazy, not my Lucy, she will be afraid of the other children, they will beat her up . . ." These and similar remarks are used by parents in an attempt to forestall the admission, and avoid facing separation from the child.

The goals of the social worker are to help the parents prior to admission in making their own decision through the interpretation of the treatment, through a visit to the ward and explanation of the programme and milieu where the child will live while in hospital. The decision is usually reached in a conscious way when parents are ready to face the reality of their child's problem. The hospitalization of the child in the psychiatric ward is not an attempt to separate the child and his family solely for the sake of separation. Everything is done to enhance a closer co-operation between the parents and child to maintain the continuity of the child's place in the family life.

Goals of Therapy. It would be presumptuous to think that within the relatively short time of a child's stay on the ward the totality of the parent-child interaction can be treated. It is possible, however, to identify some of the complex feelings that exist between the parents and their child and to help them understand some of their inter-relationships. Parents come to the diagnostic and treatment process, which is an integral part of their child's hospitalization, with an accumulation of months and frequently years of pain and distress. At the time of admission the patterns of parent-child relationship have reached an impasse.

One of the purposes of involving the family is to assist the parents to take action once again, but with a clearer view of their individual and mutual needs. It should be emphasized that we consider the diagnostic and treatment process with the family only a beginning step, a link in the chain of the total rehabilitation program. The casework treatment is set in motion by the social worker who helps both parents, individually and together, to express their bitterness, their confusion, their resentment, and shattered hopes about their child's psychiatric condition. The parents are encouraged to observe and reflect on their thoughts and feelings, to make connections between pertinent fragments of experience, to evaluate past and present behaviour, to discern between the reality of their child's situation and their wishes for him. They begin to express their frustration and their bewilderment, as well as their hopes and joys, to consider their own needs as they examine alternative solutions for themselves and their child. Too often parents, under the influence of recalling to memory the history of the child's difficulty, may feel forcefully confronted with the role they played in the child's problem and might then blame themselves. This insight however, is only of a momentary nature. This is only a peripheral understanding that cannot be accepted or tolerated too long.

One of the important goals of the casework treatment is to assist the parents toward arriving at some resolution of their painful, conflicting feelings, of the anger and guilt that torment them in relation to their child's problem. If this aim is partially achieved, the parents will experience a resurgence of whatever hopes they have and they will then be able to deal with the problem more effectively. Too strenuous an attempt on the part of the social worker to have the parents accept the medical diagnosis or follow recommendations may result in making the parents more cautious and guarded. They would view the social worker only as an extension of the doctor and not feel free to disclose their feelings.

As we work with parents towards a new solution of their conflicts, the reality of the home situation and of the child's behaviour is always present with the child's weekends at home, and with the parents' frequent visits to the ward. In the end phase of the child's hospitalization he is helped to go back and live at home; concurrently the parents are helped to lessen their dependency on the

social worker; skilful casework may remove the parents' temptation to regress to a dependent relationship. The parents come to treatment with some strengths; the casework provides a new experience that will reaffirm their integrity as parents and set in motion new energy to cope with their child's difficulties as well as many other family problems. Following discharge the parents and the child continue treatment which was set in motion through a forceful involvement of the family with a new experience, i.e. the child's psychiatric hospitalization.

Concurrent Group Work with Parents. In addition to individual casework, parents are offered the possibility of participating in a weekly parents' meeting. Most of the parents attending the meetings are in casework treatment with the writer who took major responsibility for casework services in the ward. There was no selection of parents for participation in the group. The only criterion was to have a child on the psychiatric ward. The parents' group originated from an experimental observation of parent-child interaction. During the visiting hours light refreshments are served to the parents and children. This offered a good opportunity to watch parent-child interaction and eating habits. When a meeting of all parents was called, they responded eagerly to the formation of a group. The parents' group met regularly for 16 months except during the summer. The average attendance was 9 persons. Although mainly mothers attended, there were also fathers, even grandfathers and uncles who participated.

The formation of a group feeling was slow due to the fact that with new admissions to the ward, new parents joined the group. The parents are offered the possibility of continuing in the group after their child is discharged from the ward. When a parent first joins the group, shortly after the child's admission to the psychiatric ward, at times feeling overwhelmed by guilt and still struggling with the thought "did my child need psychiatric hospitalization?", meeting the other parents gave him or her the feeling of not being alone. Through the group meetings the parents developed a very positive attitude towards the hospital and its psychiatric ward. The parents were supportive toward each other and expressed consistent interest in the other children's development.

Family Interviewing Technique. The social worker participates with the chief psychiatrist in charge of the in-patient unit. It was felt desirable at some point for the director of the ward to meet the parents, to give his own diagnostic evaluation of the symptoms presented, the underlying conflicts and the defences used. The focus of the interview is manifold: (1) to observe and to deepen our understanding of the family dynamics; (2) to provide some understanding of the difficulties the child is experiencing by a discussion of the findings; (3) to open new areas for therapy with the parents or with the child. This form of interview provides the director with first-hand information on the level of awareness the parents have gained about themselves and about their child's emotional problem. It provides the social worker with an opportunity to observe skilled interviewing techniques, as well as with a new form of supervision.

Résumé

La travailleuse sociale joue un rôle très important auprès des parents de l'enfant qui doit être hospitalisé dans un service de psychiatrie. Qu'il s'agisse d'interpréter ou d'amenuiser les résistances, ou d'offrir certains encouragements avant l'admission; ou qu'il s'agisse de travail d'exploration et de restructuration du milieu familial alors que l'enfant est déjà en traitement, la travailleuse sociale participe au travail d'équipe de façon privilégiée. Au Montreal Children's Hospital, l'auteur s'est vue impliquée dans le procédé diagnostique et dans le plan thérapeutique où elle suivait les parents individuellement ou en groupe, et où elle participait avec le directeur du service à l'évaluation globale des familles.

THE ROLES PLAYED BY DIFFERENT DISCIPLINES*

JOHN RICH, M.D.[1]

Child psychiatric practice derived from orthodox medicine, and was modified very greatly in the nineteen thirties by the development of Child Guidance Clinics and the so-called team approach. Most people subscribe to this concept of a team, but there has been little basic discussion of the assumptions on which this team is established. This has resulted in the arising of several sub-specialties, each of which tends to grind its own axe, and to carve out a greater or lesser share of the work in competition, rather than co-operation, with the others. We have situations in which an essentially normal child is treated by the psychiatrist, while a near-psychotic parent is seen by the case worker. We have psychologists who feel put upon if they are asked to test the child, maintaining that they are more competent therapists than most doctors. We have occupational therapists who may be anything from a manual training instructor to a woman highly skilled in interpretation; play therapists who are O.T.'s without a union card, music therapists, art therapists, bibliotherapists. There are case workers who argue that treatment of children in a residential setting is their special field, group workers who point out that such children cannot be considered in isolation and are therefore better treated as members of a group. Some therapists in residential settings confine themselves to their offices, leaving the enormous therapeutic opportunities inherent in putting the children to bed to untrained house-parents. Some centres employ nurses; many of these are excellent (usually because of innate skills) others are trapped in a training which has emphasized physical care but neglected emotional aspects.

The traditional medical approach assumes that the patient has some disability and wants relief. He comes to the doctor, explains his problem, the doctor makes a diagnosis and gives advice or other treatment. In much child psychiatric work none of this applies, but we go on as if it did. Many children do not accept that they have a problem or, if they do accept this, they do not see it in terms of medical help. Accordingly they do not come, but are brought. Once there, they cannot explain their problem because they do not understand it, even if they could verbalise adequately. Very often the problem is one of reality, and not neurotic misinterpretations. Of course, some techniques have been evolved to deal with these difficulties; play is used diagnostically and therapeutically with little or no reliance on verbal communication. The other members of the team are drawn in if manipulation of the environment is required. The fact remains that most psychiatrists are much happier with a straightforward neurotic child who can be handled as if he were a sick adult than they are with an acting out aggressive child who requires an entirely different approach. Such psychiatrists hand these severe problems back to the social agencies, excusing this by saying that the child is not a medical problem. Over and over again one hears of a residential treatment centre which sets out with big ideas and soon starts excluding the children who really need help because "they disrupt the program". In short, we select children for treatment, not treatment for children.

This is legitimate for an individual doctor. A psychoanalyst has every right to confine his practice to those patients who are likely to respond to the limited range of techniques he has to offer, just as a surgeon will select cases for a particular operation. As a profession, how-

*Based on a paper read at the Annual Meeting, C.P.A., Banff, 1960.

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ever, we have a wider obligation. If we do not know how to treat these children, we should find out, and to do this we have to challenge many of our assumptions. Whether or not a psychiatrist recognises the importance of this group depends largely, I think, on his practice. Those who work in a purely out-patient setting (or even more, in private practice) have a selected case load. The same consideration applies to psychiatrists writing on juvenile delinquency. Only a very small proportion of delinquents (say 2%) get to a Clinic, but many writers, such as Friedlander, generalise from this to delinquents as a whole. Readers who feel that out-patient children are roughly typical of the problem would do well to spend some time watching institutional staffs trying to cope with all those others who were "unsuitable for treatment".

It is possible that one block arises from our assumption that we ought to be in charge of any team in which we work. It is inconceivable that a surgical team could function without a surgeon, but it is salutary to recognise that much very effective therapy is carried out by social workers, club leaders, teachers and others. It has been said (was it Redl?) that we should not think of the others as being ancillaries to the doctor, but that all of us, including the doctor, are ancillary to the parents.

There was an excellent paper on lines of authority by Paterson in 1958. He distinguishes structural, sapiential, personal, moral and charismatic authority. This last, dependent on a God-given grace, is of great help to doctors when we have little else to offer, but danger arises because we come to believe in it ourselves. Apart from that, the important distinction in this context, is between structural and sapiental authority. According to Paterson structural authority derives from a man's position in the organisation and involves the right to give orders. Sapiential authority derives from superior knowledge; an expert is an "authority" in this sense. Such a person gives advice and instruction. These two forms may or may not be vested in the same person; Paterson gives a ball team as an example, in which the structural authority lies with the manager, sapiential authority with the coach.

It is commonplace that the less claim a person has to sapiential authority, the more likely he is to fall back on structural authority, to enforce obedience because he cannot earn it. This is no small point. We cannot expect people in authority to relinquish this power until they are secure enough. This causes, in my experience, the greatest difficulty in achieving a re-assessment of the roles played by the various disciplines (see also Galbraith, 1960 on "Conventional Wisdom").

If we accept responsibility for a wide range of interpersonal (and therefore social) problems, what are the requirements of therapy? These may include correction of nutritional, housing and recreational deficiencies, specific medical treatments, coaching in school work, resolution of neurotic conflicts, and provision of good parent substitutes. It is immediately clear that the psychiatrist cannot usually hope to provide more than a part of this treatment. If the problem lies almost entirely in neurotic conflict, he can do so, but he cannot be a substitute parent. In my view, it is quite false, and also cruel to equate the transference relationship with this. It is cruel, because a child (unlike an adult) does not simply need a temporary substitute on which to project his emotions, he needs a real live parent who will be there whenever he needs him. It is true that the neurotic child with parents of his own may require only the former, but the deprived child, the ward of the Children's Aid Society, needs something quite different. Even though he has many problems concerning parental relationships it is much more effective, and usually essential, to work through these in real life, not in the doctor's office. An-

other point arises here. The adult who asks for guidance and decisions may properly be referred back to himself for the answer. It is unreasonable to do this to a child because his failure to have the answers often lies in his inexperience, not in any neurotic block. In other words, as soon as we assume responsibility for a child we assume some responsibility for his upbringing, as well as for his treatment.

This presents a problem. If a child has a violent hostility to authority, he needs three types of relationships: (a) an authority with whom to work through the problem; (b) a parent figure from whom he will accept upbringing; (c) a neutral figure, not in a position of authority, with whom he can discuss the other two relationships. Now it is clearly best if (a) and (b) can be found in the same person, to avoid creating or aggravating a conflict. In practice, the psychiatrist usually plays role (c) but, as we have seen, this may never be very important compared with (a) and (b).

If a psychiatrist is a consultant to a school or agency, he usually falls into the role of having sapiential but not structural authority, and this enables him to advise the real parents or parent-substitutes, and to treat the child without confusion of role. In the residential centre, however, he often has structural authority which has many disadvantages. It identifies him with "Them" against whom the child is often fighting, it forces him to take sides in any conflict of interests among different children, and it puts him in the position of a father who is hardly ever available. It will be remembered that much of the total treatment will not derive from the psychiatrist himself and so, in both these situations, he must recognise that other people will have a sapiential authority superior to his own in some areas. His traditional charismatic—"God-given grace" — authority often blinds both the doctor and others to this fact.

No fixed plan can be laid down for the structure of every psychiatric team or hospital. In outpatient work it is possible to have a flexible system in which various members play different roles with different patients. The approach there is to start with the child (not with the staff) to specify what are his treatment needs and then to decide which members of the staff can best provide them. This cannot, of course, apply to in-patient practice except as a fairly permanent arrangement. It is essential there again however, that planning starts with the children. What are their needs? Who are the best people to apply each of these? If one is really honest, it is surprising how often the people who traditionally play certain roles are not the right people after all. It may even be necessary to create new roles or to coalesce old ones —"Child Care Workers" are a case in point.

Finally, if it is argued that all this is outside the scope of Medicine, let me defend my case by quoting the motto of my medical school "Homo sum; nihil humani a me alienum puto".

Résumé

Devant l'attitude des médecins et des psychiatres d'enfants qui ont tendance à choisir les cas les "plus susceptibles de répondre au traitement", l'auteur rappelle le rôle des disciplines qui se sont intéressées, même avant les médecins, à la réhabilitation des enfants difficiles. Il faut bien définir les besoins de l'enfant et décider quels membres de l' "équipe" peuvent le mieux y satisfaire, plutôt que de s'acharner à revendiquer une hiérarchie artificielle.

Book Reviews

Clinical Child Psychiatry. Kenneth Soddy. 470 pp. Baillière, Tindall & Cox. London. 1960. 42s.

After the publication of Kanner's textbook of Child Psychiatry in 1935 there was a long gap before the next American text appeared. This is the first text on child psychiatry from Great Britain.

The outcome of 20 years experience in child psychiatric practice, this book is intended both for those who are working with children as part of a child guidance team, as general practitioners, or as public health nurses. It is divided into 10 parts.

Part I deals mainly with heredity and environment in relation to life in London and southern England.

Parts II-VII are concerned with problems of developmental sequences from gestation onwards, with many excellent case histories, results of examinations and comments.

Part VIII depicts (especially interestingly) through illustrative case histories, the impact of disorders in parents on family relationships and on the children.

Part IX deals with child guidance methods of examination, diagnosis and disposal.

Detailed methods of psychotherapy are not dealt with as they are rightly considered by the author to present special problems to be overcome only under supervision.

Throughout the book interpretation of child developmental phenomena is broadly psychobiological and not based on any specific school of psychopathology.

Case histories are discussed according to the different developmental levels and a wide variety of problems and diagnoses are outlined.

A rather scanty bibliography is mentioned in footnotes.

On the whole, this is a valuable introductory general textbook, chiefly notable for its large number of excellent case histories.

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Child Development and Child Psychiatry. Published by the American Psychiatric Association.

This is No. 13 in the psychiatric research reports published by the American Psychiatric Association and covers a regional research meeting held March 18th-19th, 1960 in Iowa City. This collection of papers can best be described as uneven in value and quality. The main emphasis, of course, is on developmental studies—some of which are based on actual research, but some are based on extensive reviews of the literature. It is very difficult to be very positive in one's comments but this is understandable because most of these studies are broadly developmental (following the broad path made by Dr. Arnold Gessell) and the articles thus open up new ideas and possibilities rather than delineate specific findings.

This regional research conference was dedicated in tribute to Dr. Arnold Gessell in his 80th year and thus tributes from Leo Kanner should be read by all interested in child psychiatry. One other article that I feel should be especially noted was the study of the effect of hyperbilirubinemia on the premature.

In Summary, there is a little bit for everyone in this report and the reviewer hopes that the studies reported will lead on to more definitive findings.

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